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U. OGDEN, M.D.,	}	.. ..	<i>Consulting Editors.</i>
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# THE Canadian Journal of Medical Science.

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TORONTO, JANUARY, 1881.

## Original Communications.

### BRAIN LESIONS AND FUNCTIONAL RESULTS.

BY DANIEL CLARK, M.D., TORONTO.

(Read before the Canada Medical Association, at Ottawa, Sept. 1st, 1880.)

There is great danger in medical research to accept as theories preconceived notions based on a few isolated cases, and then to fortify these dubious interpretations of physical or mental phenomena by dragging in, neck and heels, every iota which seems to corroborate our views. On the other hand, the ardent but discreet investigator will adopt no great general principles until he has at his command sufficient data upon which to base them, beyond the bare presumption of vague probabilities. Richet, in his "Histology and Physiology of the Cerebral Convolutions," says in the preface: "There is nothing more baneful than to treat hypotheses as certainties. On the contrary, when serious criticism has revealed the defects and feebleness of an experiment, a real service has been rendered, for it may incite to new experiments and unequivocal conclusions. Inductions from probabilities or ill-demonstrated experiments are unreliable, and intelligent scepticism is more valuable to the advance of science than unbridled enthusiasm."

This honest expression of such an investigator should lead us to pause before drawing conclusions and establishing theories with insufficient proofs. It will be seen in the cases adduced of lesion of the brain, that this organ can stand more rough treatment in many of

its parts than almost any other organ of the body. In fact, such laceration of its delicate structures can take place without any serious mental or physical disturbance, that we almost unconsciously take for granted that many parts of it must be of secondary importance in the animal economy. It is true that a large majority of those injured in the brain are afterwards afflicted with such diseases as epilepsy, paralysis, head distress, loss of memory, and the like; yet it is remarkable how many examples of the most extensive lesions of the brain can be found with no such results. In a monograph published by me a short time ago, I endeavoured to show that localization of functional power resided only in the basal ganglia, and that the masses of cerebral substance above them were only depositories of nervous energy. If this opinion be based on a physiological fact, it would help to solve this enigma.

It is well known by all medical readers that a sharp controversy has been carried on, and antagonistic opinions have been uttered by the leaders of thought in our profession, on the functions of the convolutions of the brain. They have been mapped out with the accuracy of the streets of a city, and each district has been allotted its own work to do. Although no dividing line exists in the substance of the brain, yet the comparatively slender divisions of many of the sulci are made to be boundaries of functional energy, in which great differences of operation exist. It is not the province of this paper to take up this subject in detail, but rather to show by the record of cases how foreign bodies and diseases can virtually destroy many of these so-called



centres without any commensurate functional disturbance such as might be expected if these parts were distinct organs; also to show that mentality is not interfered with in these cases to the extent which at one time we were led to believe. The psychical results would be a good nut for the bumpologist to crack in these days of infidelity in the doctrines of Gall and Spurzheim.

All anatomists know that although the fissures of the brain in man maintain a certain degree of uniformity in direction and outline, yet the differences in detail are considerable. It will also be observed that these fissures do not make distinct divisions of the surface. The even continuity of the surface of every convolution, by means of an isthmus (so to speak) at the extremities and sides of each, indicates no striking dividing line between each of them. The dips in the grey matter, lying underneath these fissures and in proximity to the white substance, show that a certain degree of uniformity in quantity of grey matter is present throughout the periphery of the brain. It is true that differences in cell formation are seen in the various layers of the cortical substance, but these cellular distinctions are found only in each layer. There is no physiological distinction found in the various convolutions distinct from one another, to account for the varied functions in these so-called motor centres, as claimed by the Ferrier school. The uniformity of cell structure in the separate layers of the cortical substance is continuous, and nowhere bounded by the surface fissures and convolutions. In other words, all the convolutions are similar in structure, and were sections of each cut out from without inwards, and submitted to the closest analysis, no microscopist could tell where to locate each part. All are as uniform as would be sections of the cortical substance of the liver or kidney. If we compare the convolutional structures of the cerebrum with that of the cerebellum, it will be seen that they are constructed on the same plan (Richet). In the region where the distinctive giant cells exist (i.e., in the fine layer type of the ascending frontal and parietal convolutions), all the cortical regions of grey matter have no distinctive anatomical

characteristics except the presence of giant cells. Charcot suggests that all the different sized cells may be of the same kind in different degrees of development. In this way he thinks it possible that even motor centres may change their centres. This is a convenient theory to account for the fact that such an attack as aphasia often passes away, although its so-called motor centre remains impaired.

This want of dividing lines on the external surface of the brain is, on physiological grounds, a momentous objection to distinct centres in the cortical substance. Let us now consider this subject from another point of view. Fritsch, Hitzig, and other experimenters, agree that in no appreciable degree do mechanical or chemical agents excite motion in the cerebral substance. Excitation by galvanism is said to be very feeble and very limited in either the cerebrum or cerebellum, and this want of response is seen throughout. It is evident that in this way—powerful as the agent is—no functional centre could be found on the surface. Herrman shows that even after the grey matter is destroyed by chemical cauteries, a very feeble current of galvanism applied to this surface produced a slight movement, and significantly adds that in cutting away slices from the brain, the effect was more decided in proportion as the *central regions were approached* (Richet). In other words, the focus of nerve energy seemed to be in the ganglia at the base of the brain, and that the destruction of the cerebral substance did not produce that disturbance of the system commensurate with the loss of substance once supposed to be so necessary to the continuance of physical life and mental action.

Richet says, in speaking of the localization theory as propounded by Ferrier and his ardent followers, that "Absolute inflexible localization of the motor zones is impossible. There are zones which encroach upon each other, but none of these zones have limits of determined, vigorous constancy. The best proof of this is the difference existing among authors." If this mean anything, it is that although paralysis and abnormal functions of the brain in many instances follow the destruction of certain cortical parts, or are the results

of disease, and although a certain degree of uniformity in physical results follows, yet it is equally true that these same areas may be destroyed without any such manifestations following. Their own experiments are taken as proofs of this fact. These circumscribed areas cannot, therefore, by any show of reasoning, be the organs which are the centres of distinct functional activity. These local changes may affect the co-ordinating and mental powers, but the centres of these activities must be sought for elsewhere.

To reconcile these undoubted variations in results, and possibly arrive at the truth, let it be assumed that the basal ganglia are the centres of these functions. Let it also be assumed that the cerebrum and cerebellum are not directors of motion, but only *conservators* of nerve energy, both receptive and functional. Let us say that these ganglia are focal centres to all the nerve tracts of the system. Whatever nerve injury may do in other parts of the nerve mass within the skull without dangerous results, it is evident by experiments and the havoc of disease, that no serious impairment can take place in all or any part of these ganglia without disaster; hence their supreme importance: in fact, this focus of influence might be called the metropolis of life. Maudsley, in "The Pathology of Insanity," says: "The disturbance of the cortical cells is in reality secondary; it is a reflex functional result of the primary morbid action that is going on in the neighbourhood." And again: "Portions of the hemispheres may be cut away without the patient feeling it, though he is fully conscious." Ferrier locates the motor centre of the opposite upper limbs in the upper part of the *ascending frontal convolution*: in the *first frontal convolution*, the movements of the head; in the *second or centre convolution*, the motive power of the facial movements; and in the *third convolution*, the centre of the movements of the tongue and lips in monkeys, and the centre of the faculty of articulate speech in man. This is often called Broca's convolution. In the *superior parietal lobe* is located the centre for the movements of the lower limbs.

The *gyrus angularis* is said to possess some

influence over sight. Dr. Laffont, in a paper read before the Paris Anatomical Society of last year, states that "the centre which controls the circulation of the abdominal viscera is in the floor of the fourth ventricle, because local irritation of this part produces unusual activity in the blood movement of the liver and intra-abdominal organs." Other investigators equally credible say that the grey substance of the fourth ventricle is the motor centre of respiration; the occipital lobes, the centres of vision.

Aphasia, or the loss of ideomotor coördination, is circumscribed by some to disease or injury of the posterior part of the third left frontal convolution. In passing, it may be said that Ferrier still farther divides his functional foci, and puts "subjective auditive sensation" in the first temporal convolution, and "subjective olfactory sensation" in the *cornua ammonis*. In short, it may be said that, in cerebral localization, the encephalon does not represent a homogeneous organ, an unit, but rather an association or a confederation composed of a certain number of diverse organs. To each of these organs belong distinct physical properties, functions, and faculties (Charcot). It is well to keep these views in mind and see if they are corroborated by facts.

It is to be remembered that there is no direct nervous communication with the body from the cerebrum and cerebellum except through the basal ganglia, notwithstanding statements to the contrary. Whatever injury disease or traumatic lesion may inflict on these upper nerve masses with comparative impunity, analogous injury from the same causes cannot be inflicted on the central or base organs without dangerous results. In other words, these are, in my opinion, the true motor and sensory centres of the system, and there is no necessity of going beyond them to prove a localization theory. The distinction between these by well-defined boundaries and the want of uniformity in structure point strongly to distinct functions. The outshoot of the spinal cord, and the numerous nerve ramifications, not only to the organs of special sense, but also to the locomotive and organic systems,



point out these districts as being the peculiar focal centres of functional and psychical life. If this theory be correct, it can explain all the phenomena manifested by experiments made, and pathological conditions found, on the cortical substance, without resorting to the chart made out by such shifting, incomplete, and changeable boundaries as the sulci of the convolutions afford. The "bumpologist" conveniently locates all mental centres in the cortical substance nearest to his manipulations, and ignores all the similar surfaces at the base and between the hemispheres, because this *terra incognita* is not convenient to map out. He cannot reach these parts; therefore they must be useless appendages. He forgets nature has no lumber room. In somewhat the same way the Ferrier school of investigators find certain functional disturbances following the abrasion, excision, or galvanism of definite cortical parts, with a considerable degree of uniformity. Based on these manifestations, already, with considerable confidence, it is said nearly all the functions of the body are located on the exterior part of the nerve mass, which is within reach of experiment, and somewhat hasty conclusions are drawn from the results. All the rest of the brain mass, which has a substance exactly similar in structure to the external grey matter, is practically ignored, in spite of its paramount importance, which is evident from the complexity of the structure, and from the fatal results which flow from injury to these central parts. It seems to be overlooked that any injury to the cortical substance must necessarily affect the lower ganglia, to which it lies in juxtaposition, and to which it stands so nearly related. The periphery of the brain doubtless has much to do in stimulating to action these centres. In the latter are found the distinctive seats of functional activity, and in the superimposed mass the residuary power to impel, but not to direct—to give additional vitality, but not to indicate the mode and direction this force is to take. This discriminative power is left to be performed by these central glands, which are safely situated in the centre of these sympathetic and active auxiliaries. Not only is this true in respect to function, but it is equally

true as respects sensation. Sensation and function have a community of interests, and are *focalized* together. Dr. Symonds, in the Gulstonian lectures, says: "Pain does not seem to be in the nervous matter, whether vesicular or tubular, of the cerebral hemispheres, or of the cerebellum. No evidence of feeling has been obtained by vivisections till they approached the sensory ganglia—the *thalami optici* and *corpora quadrigemina*. But these are the centres of sensation to all parts of the body as well as to the head."

(To be continued.)

## PLASTIC OPERATIONS ON THE EYELIDS.

BY R. A. REEVE, B.A., M.D.

Lecturer on Ophthalmology and Otology, Toronto School of Medicine, and Surgeon to Andrew Mercer Eye and Ear Infirmary.

(Read at Meeting of Canada Medical Association, Ottawa, Sept. 2, 1880.)

I need hardly remark that *pari passu* with the advances of the past few years in general surgery, new operations and improved surgical methods have been introduced into ophthalmology. Procedures which were not thought of a few years ago, or not practised because not considered feasible, are now carried out with success. The restoration of the eyelid by transplanting a flap *without* pedicle (see case one), is a striking instance in point. To refer only to others somewhat akin, formerly it was regarded as quite creditable to relieve symblepharon where the lid was only partially adherent to the eyeball. Now, by transplanting conjunctiva from the lid or globe or both, cases of extensive union can be cured or materially relieved. And even where the whole lid has become fused to the eyeball, and conjunctiva could not be used, the delicate skin of the lid has been utilized, being drawn through a button-hole incision in the tarsus after the latter had been dissected free from the globe. The conjunctiva of rabbits has already been successfully transferred to the cul-de-sac of the human eye, and portions of cornea have also been transplanted; and the day may not be far distant when men will be enabled to see their fellows, and perhaps gain a livelihood, by means of the cornea of other animals.

The cases which I have the honour to present illustrate some points in recent improved methods of correcting deformities and removing diseased conditions about the eye by plastic operations.

CASE 1.—*Complete ectropion of upper and lower eyelids treated by transplantation of flap without pedicle.*

The patient, Flora McQ., æt. 12, was admitted into the Andrew Mercer Eye and Ear Infirmary (Toronto General Hospital) on Aug. 12, 1879. On Dec. 30, '78, she received a severe burn on the right half of the face. Cicatrization was completed in about three months—at the end of March, '79. Present condition: The patient is healthy and well nourished. There is complete eversion of both eyelids on the right side, the conjunctiva being vascular and somewhat hypertrophied from exposure; but the eyeball and *edges* of the lids are intact. The margin and cilia of the upper lid take the place of the eyebrow, which has been destroyed; and the edge of the lower lid is drawn down so as to form in part the upper border of a large, raised, and indurated cicatrix, which extends from the mesial line on the nose to the angle of the jaw. The skin above and on the outer side of the orbit is almost altogether cicatricial, being pale, very thin, and mostly glazed. The subject presented a most unsightly appearance. As the general integument was quite healthy, and it seemed impossible to get a large enough flap from the forehead without danger of sloughing, I decided to transplant one from a distant part, without a pedicle. This method, originated by Wolfe, of Glasgow, and already followed a few times on both sides of the Atlantic, would, at least, not increase the deformity if it should fail. The keloid character of the cicatrix rendered marked contraction somewhat improbable, and at any rate immediate interference was indicated in order to prevent inflammation of the cornea from exposure.

The operation was done on August 13. An incision was made a little above the margin of the upper lid and another just below that of the lower, and some dissecting done until the lids could be brought together in the normal position, when their free edges were united by

sutures at three points which had been pared.

The raw surface on the upper lid was of triangular shape, and was an inch and a quarter long at its base, its vertical diameter being the same. To cover this, an oblong piece of skin two and a quarter inches long by about the same width in the middle was dissected off the arm from the inner aspect of the biceps, thoroughly freed from all subcutaneous tissue,—being dipped into warm water, from time to time,—and was trimmed and fitted, being left somewhat larger than the area to be covered so as to allow for further contraction. It was then carefully adjusted in position, being puckered slightly in the middle, and especial pains taken to make the edges coapt with great nicety. To effect this the better, and prevent incurving or displacement, three sutures of the finest silk were put in, but were only passed through the epidermis.

Instead of covering also the lower raw surface by transplantation, as had been intended, I merely utilized a triangular piece of the skin taken from the arm, one-third of an inch long by one-fourth wide at the base, placing it at the inner angle, and adjusting the edges carefully, without any stitches, and leaving the rest of the denuded surface to heal by granulation and grafting.

The upper and lower lids were then covered with gold-beater's skin, and upon this a thick compress of cotton wool and a bandage were applied.

No pain or inflammatory reaction ensued. Forty-eight hours after the operation (Aug. 15) the bandage and wool were removed and readjusted. As seen through the gold-beater's skin, which, by the way, was left undisturbed on the upper lid for about a fortnight, the edges were coapted and dry: So also on the fifth day, as indicated by a fine dark line as of dry blood, excepting on part of the lower border where the flap had retracted a millimeter. Just above this the skin seemed somewhat puffy, the rest being smooth and apparently closely adherent to the subjacent surface.

In a few days the epidermis separated at the spot where the skin was swollen, leaving



a small moist patch of the true skin such as would be caused by a tiny blister; but the greater part of the flap retained its epidermis, and, indeed, looked as if it were the normal tissue of the part, save that it was paler than that of the opposite side.

On the eleventh day, Aug. 23, the gold-beater's skin was still attached to most of the flap, which was all firmly united. On the seventeenth day the patient was presented at the meeting of the Toronto Medical Society; the small excoriation still persisted, and owing to tension caused by contraction of the large keloid cicatrix, the lower lid had separated from the upper about a quarter of an inch at the inner canthus. Hoping to effect a still greater improvement, and by keeping the lids united and distributing the traction to be able to prevent further eversion of the lower lid, another operation was done; an incision was made below the eyelashes, and after a little dissecting to relieve tension, the lids were reunited near the puncta, leaving a raw surface one inch horizontally by three-quarters vertically. To cover this a piece of skin,  $1\frac{3}{4} \times 1\frac{1}{4}$  inches, was dissected off the arm, carefully cleaned and trimmed by means of scissors, and then adjusted; gold-beater's skin, cotton, wool, and bandage being applied.

The next day a thin layer of the discharge from the excoriated surface on the upper lid and the conjunctiva was found covering the lower lid, but the flap was adherent all around, though swollen in the middle. The parts were bathed with weak carbolic lotion, and the dressings reapplied.

On the third day the same state of things existed; the transplanted skin was thin and free from moisture at its margin, closely applied to the surrounding skin, and apparently well attached in situ. In a few days the epidermis peeled off, leaving the moist true skin, which soon healed over, *without any granulations developing*; but the inner suture cutting out again, the tension on the free edge was re-established, the new skin became much reduced in size and the inner part of the lower lid again drooped somewhat.

The patient left the hospital, Oct. 3, '79, the intention being to divide the bands of adhesion at a subsequent date, possibly not until the large cicatrix had ceased to contract, when also another operation would be done to correct the remaining ectropion.

(To be continued.)

## CANCER OF OMENTUM,

UNDER THE CARE OF W. T. AIKINS, M.D.

For the following notes we are indebted to Mr. H. W. Aikins, M.A. :—

Mrs. J., æt. 48—Still menstruating. First seen by Dr. A. upon October 25th last; prior to that date had for several months "not felt as well as formerly," and it was stated by one of the relatives after her death that she had been losing ground for as much as two years previously. About October 4th she first detected a "lump" situated in the abdomen, upon the right side of the median line, between the navel and cartilages of the lower ribs, rapidly increasing in size. When first seen by Dr. A., it was about the size of his wrist, and four inches in its vertical length. There was a question raised at first as to whether there was a fecal accumulation in the colon; this idea, however, was soon abandoned. In the early progress of the case the liver was not found to be involved, though during the last ten days or fortnight it was pushed partially beyond the costal cartilages of the ribs.

Skin examined upon various occasions, and found satisfactory:

Urine examined on two or more occasions and found normal:

Temperature very slightly elevated until a few days before death, and pulse slightly quickened:

Irritability of stomach for over a fortnight preceding death, and jaundice markedly present during last eight or ten days.

Death occurred 4th December.

*Post-Mortem.*—Limited to abdomen, made 36 hours after death: Body well nourished; surface jaundiced; abdomen discoloured and tumid; the discolouration being due to the employment of concentrated St. Catharines water as a topical application. From half a dozen to a dozen blackish crusts distributed over surface, one of which, having been cut through in the central incision, appeared to dip down into the subcutaneous fat. The peritoneal cavity contained between two and three quarts of bile-stained fluid. On deflecting the flaps, a large pancreas-like mass in mid-abdomen came into view, stretching across from



side to side, which proved to be the shrunken remains of the great omentum, thoroughly infiltrated with cancer. This was adherent to the abdominal wall on the cadaver's, right side of the median incision, but was quite free to the left. The mass enveloped a portion of the colon, and was attached by continuity of growth to the lower border of right lobe of liver. The gastro-hepatic omentum likewise was involved. The parietal subserosa contained numerous scattered deposits of new growth, and the ovaries were likewise implicated, one containing besides a blood cyst. On the left the descending colon, as well as the junction of the transverse, was folded over in front of the neoplastic omentum—i.e., between it and the abdominal wall. Circumstances did not permit of a further inspection.

#### ACUTE SPINAL CONGESTION.

UNDER DR. GRAHAM'S CARE.—REPORTED BY  
MR. DUNCAN.

P. O'Connell, æt. 33, born in Ireland, labourer, admitted into the Eye and Ear Infirmary (T.G.H.) July 17, 1880, with trachoma and vascular keratitis: present examination Sept. 8th. Married 10 years ago; four children, all living.

*Hereditary predisposition.*—Father died young; doesn't know cause of death; never knew anything about mother; never had brothers or sisters.

*History.*—Enlisted and was sent to India in '66; about one year after ('67) had soft chancre apparently. No subsequent manifestations, according to his account. Was healthy up to that time.

Same year ('67) had fever and ague; lasted off and on for three years. Then, for the latter part of time there, had "jungle fever" off and on during hot weather; as a result of this latter fever, had palpitation of heart for eight months. Was then invalided home ('71). One month in English hospital. Went to Ireland; stayed there 1½ years; came to Canada ('72). Eyes began to trouble him two years ago; 18 months ago inflamed so was obliged to give up work; heart and costive bowels have troubled him since that time.

*Present disease.*—Saturday, Sept. 4th, had taken a bath; afterwards felt numbness of right heel, but had often felt it so before, therefore thought nothing of it. Next day felt left heel numb in same way, and on Monday same feeling in little and ring fingers (both hands), and

the numbness extended up and affected both arms. On Tuesday, the legs got numb gradually from below upwards, reaching the body. Tuesday took to bed; feels getting worse constantly.

*Present condition.*—Half sitting in bed; is sure he could not walk; feels like a lump of lead all over. Neck and every part of the body and limbs stiff; head cool, feet very cold, hands and body moderately warm; general anæsthesia. Pulse, 84; respiration, 24; tongue clean; no appetite; some thirst.

Soreness along spine, head, jaws (especially when opening them) chest, and all over. Partial but increasing paralysis of legs and arms.

Sept. 9th.—Worse; eats nothing; feels as though cord tied around chest; respiration laboured; cyanotic before death; power of deglutition gone. Died in the evening.

Sept. 10th.—P.M. by Dr. Zimmerman. All the organs—heart, stomach, &c.—healthy except brain and cord, liver and kidneys, which are reported as congested. Nerve centres saved for microscopic examination.

#### DISLOCATION OF THE INFERIOR TIBIO-FIBULAR ARTICULATION.

BY A. M'PHEDRAN, M.B., TORONTO.

On Nov. 22nd, 1879, J. D., a young man working in a planing mill, while walking over some lumber, fell, with his foot turned under him, injuring the ankle. He was brought to me a few minutes afterwards, and on examination I found the foot considerably inverted and slightly extended, and the ankle admitting of but little passive motion. The external malleolus was displaced forwards, apparently lying in front of the ridge forming the anterior border of the external surface of the lower end of the tibia. Measurement from the malleolus to the tendo achillis was about twice what it should be.

On grasping the foot by the toes and heel, and everting it, the malleolus returned to its place with almost as distinct a sound as is heard on reducing a dislocated shoulder. Complete recovery resulted in a few weeks.

Hamilton, in his work on "Fractures and Dislocations," says there is only one case of dislocation of this articulation on record. It was reported by Nélaton, and occurred in the practice of M. Gerdy. It was caused by the passage of a cart wheel obliquely across the leg, pushing the malleolus backwards, so that its posterior border lay almost in contact with the tendo achillis. It was not seen till the 39th day; and as there was but little interference with the movements of the joint, no attempt was made to reduce the dislocation.

## PLEURISY—ASPIRATION.

BY R. WHITEMAN, M.B., SHAKESPEARE, ONT.

I was called, September 14th, to see a patient, who, I was informed, had been ill for some time with inflammation of the lungs. On enquiry, I was told that he was not at the time under medical treatment.

He informed me that his name was Robert Gordon, age 24 years, two years out from Ireland; had been working on a farm. In the early part of harvest was ill for a time, had a severe pain in right side, and was off work for about a week, when he resumed his duties, but never felt quite so well again. Soon got out of breath, and was tired upon very slight exertion. In this way he continued until about three weeks ago, when taking seriously ill he was again laid up, and had, as he said, been able to do nothing since. I found him a stout, able-bodied man, dark complexion, slightly emaciated. Pulse 84. Respiration 32. Temperature normal. On proceeding to examine his chest, I at first noticed that right side did not move so freely as left, with complete dullness over right side on percussion, and absence of breathing sounds, also half inch enlargement on right side. I informed him that there was a collection of fluid in the pleural cavity. Prescribed salines with iron and strychnia, also blue pill, and directed him to come to my office on the 17th.

On his arrival he thought he felt better, but I found no change in physical conditions, and informed him that his quickest and easiest way of getting over his trouble was to submit to an operation; and in order to convince him of the necessity of it, I ran in a hypodermic needle and brought out a drachm of fluid.

On the 18th, assisted by Dr. D. B. Fraser, of Stratford, I proceeded to aspirate his thorax, inserting the aspirator needle between the fifth and sixth ribs, behind the median line, and brought out 79 ounces of wine-coloured fluid sp. gr. 1025, alkaline, coagulated by heat or nitric acid, and containing flakes of lymph with blood, and a few large cells, very like pus cells. He complained of some pain just after the operation, but felt that he could breathe more easily. After the operation I

put a bandage around him, having first covered the aspirator wound with adhesive plaster.

September 19th—Went to see him; found pulse 76, respiration and temperature normal. Some thirst, slept well, good appetite. Some pain at apex on deep inspiration.

September 23rd—Chest measures alike on both sides. Pulse 92 (he came to my office). Respiration 26. Temperature normal. Appetite good. Slightly costive. Can now lie on either side. Gave jalap and calomel with magnes. sulph. Continue iron and strychnia.

October 8th—Called to-day. Has been at work for the last ten days. Pulse 72. Feels, and is, in perfect health; weighs 172 pounds, having gained 26 pounds since operation.

## DISLOCATION OF THE HIP—REDUCTION BY MANIPULATION FIVE WEEKS AFTER.

Under the care of H. T. MACHELL, M.B., L.R.C.S., Edin.

(Reported by Mr. RAIKES.)

The patient, Frank O'Donnell, aged seven, was admitted into the Hospital for Sick Children, Toronto, on Nov. 14th, suffering from a dislocation of the femur, upwards and backwards, upon the dorsum ilii. According to his statement, on or about the 10th of October (five weeks before), he was sitting on a door step, when another boy jumped on his back, throwing him forwards. On attempting to get up he found he was unable to use his left leg; after being carried home, noticed a swelling and great pain in vicinity of left hip. A medical man was called in, and gave it as his opinion that "the ligaments of the joint had been stretched," and prescribed stimulating lotions and complete rest in bed, where he was confined for four weeks. When he got up was still unable to use the leg, though he managed to get about, with the aid of a crutch, with very little pain. About this time Dr. Machell saw the patient, and diagnosed dislocation upon the dorsum ilii; there was considerable freedom of motion, active and passive, with no pain.

On November 15th, just five weeks after the accident, the dislocation was reduced, under chloroform, by manipulation, by Dr. Machell, the whole operation not lasting ten minutes. A long splint was applied, and the patient ordered perfect rest in bed.

November 22nd, splint was taken off and re-applied without any pain to patient. Three days after, splint was again taken off and motion made. This was repeated every day for a week, when the patient was allowed to walk about the ward, and the splint discontinued.



## Selections: Medicine.

### THE TREATMENT OF ASTHMA BY THE INDUCED CURRENT.

BY I. BURNEY YEO, M.D., F.R.C.P.,

Physician to King's College Hospital, and Senior Assistant-  
Physician to the Brompton Hospital for  
Diseases of the Chest.

The recent discussion on Asthma at the meeting of the British Medical Association at Cambridge gives special interest to the following notes of a case which has lately been brought under my own observation. Two or three days after taking part in this discussion I found myself at the baths of Neuenahr, the guest of that able physician, Dr. Richard Schmitz; and I had an opportunity of seeing and examining with him an aggravated case of asthma, which had been treated by the application of the induced current, and apparently completely cured thereby.

This patient, a gentleman about forty years of age, had suffered from paroxysms of asthma for more than six years, originally induced, he believed, by a severe attack of catarrh. He had tried numerous remedies and visited several climates, but without any considerable relief. This year he was spending a second season at Neuenahr, but without any relief to his asthmatic attacks. Quite recently he was seized with an attack of unusual severity and duration, which had lasted, with but slight intermission, for three whole days and nights, when, as all other resources had failed, it occurred to Dr. Richard Schmitz to try the effect of the induced current applied in the manner suggested by Dr. Max Schaeffer, of Bremen. The relief afforded was immediate, and after twelve applications—*i.e.*, an application twice a day for six days—the patient appeared quite well. I examined his chest carefully, and there was no trace of wheezing or of dry or moist râles of any kind. I examined his throat, and found evidence of chronic pharyngitis, the mucous membrane being very granular from the presence of many enlarged swollen follicles; but it was quite clean, and free from mucous secretion. The tonsils were scarcely at all enlarged, although they had been much so formerly. I mention these facts with respect

to the condition of the throat, as they bear on the theory of the action of the remedy to which I shall immediately allude. The influence of the remedy had been so complete that the patient's gait and carriage were totally changed; and instead of assuming the bent, stooping figure of the asthmatic, he walked as upright as his fellows.

The galvanic current had been applied to the throat in the situation of the great nerve trunks, the vagus and sympathetic, each pole being applied just below the angle of the jaw and in front of the sterno-cleido mastoideus. The current, mild at first, was gradually increased in intensity until it could be distinctly appreciated by the patient as passing through the soft palate from one side of the throat to the other. It was continued for fifteen minutes at each sitting. It was noticed that the pupils, widely dilated at first, became strongly contracted as soon as the application of the current gave relief. Dr. Max Schaeffer, who has recently advocated this treatment, agrees in the main with Biermer as to the pathology of idiopathic asthma, meaning by *idiopathic* asthma those attacks in the intervals between which no evidence of morbid changes in the lungs can be found. He regards these attacks as a tonic spasm of the middle and finer bronchial tubes; but he looks upon the spasm as secondary, and agrees with Weber in believing the primary change to be a swelling or tumefaction of the bronchial mucous membrane, dependent on a fluxionary hyperæmia, itself due to a vaso-motor nervous influence, the principal rôle being played by the pulmonary fibres of the vagus. According to this view, asthma is an irritative and reflex pulmonary neurosis. It agrees, in many respects, with the theory of asthma adopted by Dr. Andrew Clark in the discussion to which I have alluded, and which I have held myself as the most consistent with the clinical history and phenomena of the asthmatic paroxysms.

The morbid state, upon which the asthma depends, may affect—(1) the nerve itself, or (2) the coverings of the nerve, or (3) the tissues adjacent to the nerve.

Max Schaeffer lays great emphasis on the third of these conditions—*viz.*, that morbid

states of the structures adjacent to the nerve may influence and disturb the nervous currents. Tumours such as nasal polypi, hypertrophied tonsils, swollen cervical or bronchial glands (temporary hyperæmia of these glands), can, according to their position, cause irritative pressure on nerve filaments connected with the respiratory centres. He found that many of his asthmatic patients were the subjects of nasal catarrh, or pharyngeal catarrh, or laryngo-tracheal catarrh. He noticed that swellings of the mucous membranes of these parts were attended with asthmatic paroxysms, and patients would constantly refer the seat of their discomfort lower or higher in the throat, according to the seat of the swelling, and he concludes that all the symptoms of asthma are symptoms of irritation brought on by pressure on nerves which are in connection with the pulmonary portion of the vagus, and especially in the upper part of the respiratory tract—the pharynx, larynx, and trachea.

He examines carefully the nose and throat, and applies the electrodes according to the seat of the disease. Usually the two electrodes are placed on each side of the neck about two centimetres below the angle of the jaw, and sometimes a little lower down in front of the sterno-cleido mastoideus. The current must be of good strength, so that the patient can feel the stream go across the larynx and soft palate. In bad cases it should be applied twice a day, from fifteen to thirty minutes each sitting. He states that in the most severe cases it has acted "like witchcraft." He has never found the constant current do any good, but he has never failed with the induced current.

Certainly the result of the application of the induced current in the case that came under my own observation was very remarkable.—*London Lancet.*

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PHOSPHORUS POISONING.—"In phosphorus poisoning there is one certain antidote, viz.:—Carbonate of magnesia in 3j doses every 15 minutes, until no phosphorescent breath is observed. Phosphate of magnesia is formed; the uncombined magnesia, by its mechanical action, protects the coats of the stomach from any further action of the phosphorus, and any free phosphoric acid is neutralized by it as it is formed."—*Birmingham Medical Review.*

## REDUPLICATION OF THE HEART SOUNDS.

Dr. Sansom read a paper (at the Medical Society of London) on the causes and significance of Reduplication of the Sounds of the Heart. He first reviewed the various theories adduced in explanation of doubling of the first sound. These might be reduced to two. 1. That reduplications of the first sound are *real*, and are due to a want of synchronism in the systolic tension of the auriculo-ventricular valves of the right and left sides. 2. That they are apparent, and due to an auricular immediately preceding the ventricular systole. He could not agree that the auricular systole is directly audible, but that it might cause a sound by communicating a presystolic tension to the mitral curtains under certain conditions. He adduced cardiographic tracings to prove that in certain cases of apparently reduplicated first sound the auricular systole was greatly augmented, and showed that the phenomenon might be the precursor of an undoubted presystolic murmur. As regards reduplication of the second sound, he had observed it in eleven out of thirty-seven cases of mitral stenosis. All observers are agreed that mitral constriction was the most common condition in which it was observed. He considered, from a review of the cases, that the reduplication of the second sound was often *apparent*, and due to a tension communicated to the mitral curtains *early* in diastole, just as in quasi-reduplication of the first sound it was communicated *later* in diastole. The moment the ventricle becomes relaxed after its systole, the blood retained in a state of tension (the pressure in the pulmonary circuit being heightened) in the auricle enters with force into the ventricle, and finding its way on the parietal side of the curtains of the mitral valve, causes them to bulge towards the ventricular cavity, and in so doing occasions the "click" of valve-tension, which, coming so soon after the second sound, closely resembles a reduplication of the latter. Although a frequent, it is not a universal explanation of this reduplication. In some cases it is very probable that the reduplication is real, and due to non-simultaneous closure of the semilunar valves of the aorta and pulmonary artery. He



agreed with Dr. James Barr, of Liverpool, who held that over-repletion of either of the ventricles was the cause, not of delayed but of anticipated sound.—Dr. Galabin argued that reduplication was often rather apparent than real, cardiac murmurs closely approximating cardiac sounds, especially in the case of direct mitral murmur. Thus in mitral stenosis, the presystolic might be mistaken for a loud first sound, and the true first sound for the second sound of the heart. He could not understand how valvular tension could occur when the valve was converted into an indurated ring. The apparent second element of a reduplicated second sound might be due to a short diastolic murmur of direct mitral character; and reduplication of the first sound apart from cardiac disease, due to the sudden tension of the ventricle after the closure of the valve.—Dr. Mahomed believed that reduplications of the sounds were chiefly valvular in origin, although in mitral stenosis other sounds are often mistaken for reduplication of the normal cardiac sounds. He exemplified the cause of reduplication of the second sound by the recoil of two equal pieces of elastic, the one stretched to four inches, and recoiling to three inches; the other stretched to three inches, and recoiling to two inches; if stretched simultaneously they would not complete their inch of recoil simultaneously. He thus attributed the reduplication of the second sound to the asynchronous recoil of the aorta and pulmonary artery subject to abnormal variations in pressure in either one or the other. This explained the frequency of this reduplication in mitral stenosis when the pulmonary pressure was heightened. He similarly explained reduplication of the first sound, and he believed these views were identical with those advocated by the late Dr. Sibson. He did not think deduction could be drawn from cardiographic tracings, which did not signify the time of closure of the valves.—Dr. James Barr (of Liverpool), in the course of his remarks, stated his belief that reduplication was due to asynchronous action of the ventricles, so that a normal doubling of the first sound occurs at the end of expiration from the increased stimulus to the right ventricle, and of the second sound at the end of inspiration from the

early cessation of the right ventricular systole. In disease, that ventricle which is best supplied with blood initiates the systole, although it may not complete its contraction until after the other ventricle has finished its systole; or both ventricles may begin systole together, but one may lag behind the other. He was certain that there was this asynchronous contraction of ventricles (and of auricles also), each side of the heart having its own fibres.—Dr. Sansom replied, and the Society adjourned.—*London Lancet.*

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### PART OF A CLINICAL LECTURE AT JEFFERSON MEDICAL COLLEGE HOSPITAL.

CLINIC OF ROBERTS BARTHOLOW, M.D.,

Professor of Therapeutics and Materia Medica.

#### *Treatment of Obstinate Malarial Attacks.*

The case before us is a simple ordinary one of intermittent fever. He has a chill every other day. The fever is, therefore, of tertian type, and, after the chill, the hot stage lasts two or three hours, and is terminated by sweating. This has been kept up for some time, and will prove what I say, that an attack of intermittent fever in a malarious district is not to be despised. After checking the disease with quinine, the paroxysms will recur, and the treatment will thus often be brought into discredit, unless some few points are borne in mind, as regards the method of administration. Give the quinine at least three hours before the expected paroxysm. Shall we give small doses frequently repeated, or large doses less often? The latter is the true mode. You will then give fifteen grains three hours before the expected paroxysm. I prefer this to the former method, for this reason, which I regard as indisputable: Quinine, though not eliminated from the system with great rapidity, yet is eliminated, and chiefly by the urine. If we were to give it in small doses early in the morning, by afternoon it would be eliminated, and would require to be repeated, and in larger amount, in order to check the paroxysm. Therefore, it is more economical, as well as more effective, to give a single large dose, which is also more agreeable to

the patient; for I affirm that fifteen grains given at once will give much less distress than one grain every hour until the same amount be taken. Large doses obtund the sensibility of the cerebral centres, while smaller ones cause excitement of the brain and tinnitus.

By giving a single large dose of a gramme of quinine at least four or five hours before the time for the appearance of the expected chill we break up the paroxysms. What shall we do to prevent their return? We ordinarily hear that the chills are apt to return at septenary periods; but if you will look into the matter you will find that they recur in multiples of the original number. Thus, tertian would return in six days, or if not, then on the ninth, twelfth, fifteenth, eighteenth, or the twenty-first day; and in quotidian they are apt to be manifested in multiples of two. On these critical days, the remedy should be repeated. If we break up the chill to-day, on the day after to-morrow, although he may not have a decided chill, he will have some significant symptoms, that are evidences of systematic disturbance; he will excrete more urine, he may have a diarrhoea, general muscular soreness, or something else indicating the influence of the malarial poison. We must, therefore, give our quinine again, and repeat it on subsequent days, multiples of the original attack, administered in anticipation of the former hour of the attack. On the morning of the sixth and seventh, the thirteenth and fourteenth, the nineteenth and twentieth and twenty-first days, doses of ten grains shall be given on each of these days.

What else? Do you abandon your patient in the interim? Ten grains of quinine will not be sufficient to relieve a damaged liver, or to reduce an enlarged spleen; in other words, the condition of chronic malarial poisoning. Treatment must be directed to this object as well as to breaking up the chills, or they will inevitably return. Lugol's solution, in five-drop doses, given in water before meals, and Fowler's solution, three drops after meals, always prove most efficient aids. It is best, about the twenty-first day, to give a full antiperiodic dose of quinine for three days, for by this time there is a much greater accumulation of morbid material in the blood than at the other periods named.

Please bear in mind these rules which I have just given you, for you will find that they will stand you in good stead in all these cases of obstinate malarial attacks.—*College and Clinical Record.*

## NEW THEORY AS TO THE PATHOLOGICAL CHANGES IN THE BLOOD IN ACUTE RHEUMATISM.

At the last meeting of the Cambridge Medical Society, held on Friday, Nov. 5th, Professor Paget, President, in the chair, Professor Latham advanced a new theory as to the pathology of acute rheumatism. He maintained that the first step was a lowering of the action of the "inhibitory chemical centre," or nervous centre, which controls oxidation in the muscular tissue. Following upon this, the oxygen from the oxyhæmoglobin, instead of entering the muscular tissue to be exhaled therefrom in the form of carbonic acid gas, had its sojourn in the tissue shortened, and passed into the blood in the form of lactic acid (a substance which appears in muscle almost instantaneously with its death); that the oxygen acted also more energetically on the muscular tissue, and the resulting lactic acid being oxidised rapidly in the blood, instead of in the muscular tissue, an abnormal amount of heat or pyrexia was developed.

He then argued that quinia lowered temperature by simply impeding the carrying of ozone from the lungs to the tissues by the red blood-corpuscles, as in Binz's experiments with ozonised turpentine and guaiacum; and so the remedy *might* act beneficially in rheumatism, but would have no effect on the *materies morbi*. Salicylic acid, on the other hand, lowered the temperature and cured the disease by chemically combining with the substances from which the lactic acid is derived, and producing less heat than would result from the oxidation of that substance. He showed how the theory advanced explained the relapses which so often recur after apparent cure with salicylic acid, the necessity for large doses of the remedy, and the reason why it should be less curative in other pyrexial disorders, such as pneumonia, typhoid fever, &c. Referring to locomotor ataxy as an example, he suggested that possibly the local symptoms might be the result of the lactic acid acting upon the posterior columns of the spinal cord, producing functional change; and, in reply to a question in the discussion afterwards as to the connection



between rheumatism and chorea, considered that this disorder was the result of the lactic acid inducing functional change in the nervous centre which co-ordinates muscular movement, that centre being weak, and therefore a point of minimum energy, and this condition being hereditary or acquired. He also applied his theory to explain why the same cause (cold) which in one person appears to produce acute rheumatism, in others produces pneumonia, tonsillitis, &c.

Since the meeting Dr. Latham has extended his theory to diabetes. If it be true, it ought, he says, to explain the phenomena of that disease with a normal or subnormal temperature, and he maintains that the lowered nerve action is sufficient to do this. Salicylic acid may then (whilst the patient perhaps is taking ordinary diet) cause the sugar to disappear from the urine and lessen the amount of that secretion without even altering the condition of the nervous system upon which the symptoms depend.—*London Lancet*.

#### HYDROPHOBIA FIVE YEARS AFTER INOCULATION.

—At a late meeting of the Académie de Médecine, M. Colin related the case of a patient who had just died under his care of hydrophobia of two days' duration, the result of a dog bite received in Algeria on the 2nd November, 1874. One of the man's comrades, who had been bitten at the same time by the same dog, died of hydrophobia in eight days after the receipt of the bite. That virus may be deposited locally, and remain innocuous for a variable period until accidentally absorbed into the blood, has been experimentally proven by M. Pasteur in his investigations into the "cholera of fowls."

THE STOMACH AND PANCREAS IN THE DIGESTION OF FAT.—The commonly received opinion, resulting from the experiments of Bernard and Brücke, that the oleaginous constituents of food must be emulsified by the intestinal and pancreatic juices before absorption, appears to be contradicted by the later experiments of Cash in Ludwig's laboratory, which go to show that fats are absorbed in the free state, and that their conversion into an emulsion first takes place after absorption is effected.—*London Lancet* and *Archiv. für Anat. und Physiologie*.

## Surgery.

### THORACENTESIS.

M. POTAIN.

The indications for thoracentesis result from the nature of the liquid effused into the pleural cavity—a liquid which may be either serous, or from an hydatid cyst, or blood, or pus.

In the first case, the abundance of the effused fluid and the accidents which are a consequence of it are an indication to tap the chest, also the presumption of the existence of hydatids.

When blood is effused, which can hardly be known in an absolute manner unless an exploratory puncture is practised, not a serous fluid more or less tinged with blood, but truly an effusion of blood pure and primitive, it is absolutely necessary to abstain from practising thoracentesis. It is necessary to abstain, in the first place because we are not sure that the effusion has ceased, and because an evacuation of the pleura may in these conditions favour a new hemorrhage; again, because this blood may be coagulated, and that in this case we can extract nothing, or almost nothing, numerous clots blocking up the mouth of the canula.

Finally, if the effusion is purulent, it is almost indispensable to operate, although sometimes we may have seen it absorbed. But before all it is necessary to be assured by an exploratory puncture if the fluid is truly pus or only a purulent serosity, for until then we can only have presumptions and not an absolute certainty. The motives of presumption vary according as the pleurisy is acute or chronic.

In the first case, the liquid is very probably purulent if the disease from the beginning affects an extreme intensity; if it is accompanied by a violent pain and a grave general condition; if it is the consequence of a traumatism of the chest, or even if it supervenes secondarily during the course of a grave general affection, as variola, scarlatina, puerperal accidents, etc.

In the chronic form, where the fluid is transformed little by little into pus, the prolongation of the disease and the irregular chills, as well as the œdema of the thoracic wall at the

level of the last intercostal spaces, are signs of a purulent effusion. But the truest indices are yet found in the general condition—in the enfeeblement of the patient—a pale yellow countenance, chills, and persistent fever.

Another sign has also been pointed out some years ago by an Italian physician, and certified to by M. Gueneau de Mussy to distinguish a serous from a purulent effusion. In the first, the transmission of the whispered voice can be perceived as far as the base of the chest; in the second, this voice has absolutely disappeared.

However, in investigating matters more closely, we will recognize that, if the whispered voice heard clearly as far as the base, or perfect aphonic pectoriloquy, constantly indicates a serous effusion, it is necessary to know how to differentiate in the case in which this pectoriloquy is imperfect, whether the patients speak low or loud; it is necessary also to remember that the presence of false membranes in the pleural cavity may modify and even suppress aphonic pectoriloquy.

This sign then is good only, when perfectly clear, to diagnose a serous effusion; but from the moment it has lost its clearness, it has no more value either for or against the presence of pus: and these are, unhappily, the most numerous cases.

As to the counter-indications of thoracentesis, they are less numerous. Fever has been pointed out, but in my opinion, save in a few exceptional cases, I do not admit it. It has been said that it might exaggerate the inflammatory phenomena; but experience does not prove that this is well founded, and the operation develops only a slight febrile movement and of very short duration. Far from it; the fever rather tends to fall: thus it is that in 25 operations on cases with fever, this disappeared from the second to the fifth day in 17 cases. So the operation would tend, contrarily to what has been said by some authors, to abridge the duration of the febrile state.

It is very certain that, if the patient is a prey to a violent fever and to intense inflammatory phenomena, one ought, before thinking of proceeding to any operation, to have recourse to antiphlogistics, which, in an acute pleurisy, may by themselves produce absorption of

the effusion. Likewise in cases of extreme pulmonary fluxion, accompanied by a scanty effusion, one ought to abstain. If, on the side opposite to the pleurisy, the lung is the seat of a very extensive bronchitis, the indications are variable, and we ought to act only in presence of an asphyxia or a threatened suffocation.

Tuberculosis is also regarded by some physicians as a counter-indication, even in the case of an abundant effusion. However, if this affection is recent; if it is yet only in the second, and especially in the first degree; if there exists no cavity, and if the collection is of recent formation, it appears to me, on the contrary, useful to interfere in order to evacuate the fluid mass, and permit, by so doing, the lung to be distended a little and to recover its normal volume.

Should the tuberculosis be advanced, should there exist some large cavity, act then only with the greatest caution, thoracentesis having at times produced a rupture of the cavity into the pleura, and given rise to a pneumothorax, which is in nowise an advantage. Formerly thoracentesis had been proposed for pneumothorax alone, and this had been considered one of the most precise indications for operating. This is absolutely erroneous, for the withdrawn air being immediately replaced, the operation is then of no utility.

To sum up, the indications of immediately practising thoracentesis are these: suffocation, asphyxia, and a considerable effusion distending the thoracic cavity. When the phenomena are less menacing, when you see no immediate danger, when no symptom appears to be increasing and effecting a rapid progress, operate less precipitately; but operate, whatever may be the quantity of liquid effused, if the effusion dates already for some time—if there is already a duration of from fifteen to twenty days. Finally, if no treatment has been attempted when you are called for the first time to your patient, have recourse before any operation to antiphlogistic means, to purgatives and diuretics, and if you obtain no result, practise thoracentesis.

As to the nature of the effused fluid, when you are certain or have a sufficient presumption of the presence of pus in the pleural cavity, puncture.

Such are the indications and counter-indications of thoracentesis.—*Gazette des Hôpitaux*,



## TARSAL TUMOURS TREATED BY ELECTROLYSIS.

BY JULIUS ALTHAUS, M.D.

(Synopsised from London *Lancet*.)

In February, 1880, Mr. White Cooper sent me a lady, aged 30, suffering from tarsal tumours, occupying nearly the whole of both upper eyelids, and recommended electrolysis. The conjunctiva being involved and very sensitive, Mr. Clover induced anæsthesia by his mixture. I then applied both poles of the voltaic battery by means of my four-pointed electrolytic needle conductors alternately to both tumours, so that each of them received the influence of the cathode and anode successively. Twenty cells of the Becker-Muirhead battery were used for ten minutes, after which the whole of the tumours, both inside and outside, appeared completely shrivelled up. Not a drop of blood was lost, although the subconjunctival portions of the tumour were highly vascular. The surface of the lids was covered by goldbeater's skin and flexile collodion. When seen a month later, the tumours had entirely vanished; no scar was visible anywhere, and no eversion of the lids had occurred.

**DECALCIFIED BONE DRAINAGE TUBES.**—Surgeon Shirley Deakin, F.R.C.S. Eng., I. M. D., writes to the *British Medical Journal* as follows: "In the long bones of the limbs of poultry and small birds I have found capital drainage tubes ready turned to hand. The bones, collected by the cook, and well boiled to free them from the soft parts, are soaked for about ten hours in a mixture of one part of hydrochloric acid and two parts of water. Immersed for this time they become sufficiently soft and flexible for use, and to be cut with ordinary scissors. The ends of the bone are now cut off with scissors, and the medullary canal well cleaned out with a thick wire or rat-tailed file. The bone tubes should then be boiled in a 5% solution of carbolic acid, to which some borax—an antiseptic procurable in every bazaar at a very cheap rate—has been added. The tubes are to be kept in a 5% solution of carbolic oil. If the ends of the bones are cut off with bone nippers before being decalcified,

they are very liable to split. If soaked too long in acid, the walls of the bone tube become too soft and gelatinous, and the lumen is liable to be closed by the pressure exerted by the edges of the wound into which the tube is inserted.

## TREATMENT OF FRACTURES AT THE ELBOW.—

In a recent paper, Dr. Lewis S. Pilcher draws attention to the outward obliquity of the forearm, and records some measurements he has made with the purpose of testing its degree and constancy. He has measured the angle formed by the axis of the humerus and ulna, and found that not only does it vary considerably in different people, but even on the two sides of the same subject. The full, free, and proper use of the limb depends upon this angle, and it is necessary to attend to its maintenance when setting fractures near the elbow-joint; but as the sound limb is no certain guide for the injured one, it is difficult to determine upon the normal obliquity if it has been altered by the injury. Dr. Pilcher also urges the relaxation of all muscles fixed to the fragments, and immobility of them until firm union has taken place; but we are unaware that these are other than the plainest and most universally held principles in surgery, although perhaps too often lost sight of in treating fractures near joints, from fear of ankylosis and the intervention of the bone-setting quack.—*London Lancet*.

**RARE MALPOSITION OF RECTUM AND COLON IN ADULT.**—Mr. Alfred Baker, F.R.C.S., Eng. (Birmingham), records in the *British Medical Journal* an important case of this description, in which he had performed colotomy for cancer in rectum. *Post mortem*, it was discovered that the sigmoid flexure, forming a very large curve, was in the right iliac fossa. The caecum and appendix occupied the left iliac fossa, and in the left lumbar region the caecum was found open, empty, and fixed in the operation wound by sutures. The small intestines were normally placed, except that the lower part of the ileum ran transversely from right to left to terminate in the caecum. No other malposition existed.

**BACILLUS MALARIE.**—The rods and spores of the bacillus malarie have been found *post-mortem* in the lymph, blood, spleen, and medullary cavities of bones as long ago as last autumn. The presence of the bacillus in the blood of living patients had never been demonstrated, the specimens being taken from patients during the hot stage of the fever. Lately, specimens of blood taken during the period of invasion, and in the cold stage, and during the last hours of the intermittent period, have been examined, and the bacillus found in every specimen. The spores alone could be seen when the fever is at its height. Observations are to be made in Italy of the blood of the spleen aspirated during the last hours of the intermittent period, and also of the urine and perspiration during the stage of resolution. A good illumination is required, and at least a one-eighth-inch object-glass.

Two new anæsthetics have recently been experimented with by Dr. Edward Tauber, of Jena. They are isomeric bodies, and were discovered by Regnault in 1838 and 1840, and are named respectively Monochlor-Ethylidenchloride, or Methyl. Chloroform ( $\text{CH}_3$ ,  $\text{CCl}_3$ ), and Monochlor-Ethylenchloride ( $\text{CH}_2\text{Cl}$ ,  $\text{CHCl}_2$ ). Both smell like chloroform; the former has a spec. grav. of 1.372, and boils at 167° Fahr.; the latter of 1.422, and boils at 249° Fahr. Experiments made upon animals and on himself proved the rapid production of complete anæsthesia with little or no effect upon the pulse or respiration, and no preliminary excitement or diminution of blood pressure.

#### PERFUMED CARBOLIC ACID.—

R	Acidi carbol. cryst.,	1 part
	Olei limonum,	3 parts
	Alcoholis (36°),	100 parts. M.

This mixture, which appears to be quite stable and has only the odour of lemon, is what has been known as "Lebon's perfumed carbolic acid," the formula for which has long been a secret, but has now been made known in the *Moniteur Scientifique* of Paris. The antiseptic properties are in no way affected by the oil of lemon.—*Philadelphia Medical and Surgical Reporter*.

## Midwifery.

### THE COMMUNICABILITY OF PUERPERAL FEVER BY THE MEDICAL ATTENDANT.

BY ANGUS MACDONALD, M.D., ROYAL INFIRMARY, EDINBURGH.

(Synopsised from the *British Medical Journal*.)

The observations of Mayrhofer, Orth, Heiberg, Haussmann, Spillmann, Pasteur, Doléris, and others, have within the last ten years accumulated such an amount of evidence, that it seems to me next to impossible to refuse credence to the belief that the septic changes which take place in the lying-in woman are dependent upon the action of certain micrococci, which can always be detected in the fluids of the dead, and usually also in the blood of the living who are affected with puerperal septicæmia.

According to Dr. Amédée Doléris the power for evil is taken away from septic micrococci by the addition of an equal part of a one per cent. solution of carbolic acid to a solution in which they are found.

It would thus appear that a solution of carbolic acid, which will not injure the hands of the physician, is sufficient to destroy the minute organisms on which, according to the modern idea, the poison of puerperal septicæmia depends for its existence and activity.

I therefore believe that we have now arrived at the time when we are able to state that, with the employment of extreme care and cleanliness, coupled with the use of proper antiseptic precautions, we may, without danger, attend patients suffering from puerperal fever, and do all that is required of us as doctors, without the slightest risk of communicating the disease to our other patients.

But a distinction ought to be made regarding what is the duty of a doctor as compared with what is incumbent upon a nurse. A medical man, to avoid carrying the infection, must not stoop to perform the work of a nurse. He must be careful not to expose his clothes to any discharge that comes from the patient's genitals, or that is about the bed—or indeed to allow them to touch the bedclothes,



I have seen medical men lifting puerperal patients by pushing the coated arm below their legs, and then carefully disinfecting their own hands. Such conduct can only end in disappointment. Before such an act were admissible the coat should be removed and only the bare arm used; after which, the arms and hands should be thoroughly disinfected.

In proof of the practicability of what I maintain, I may mention an experience of my own in the spring of 1879. It was then my misfortune to meet with a case of puerperal fever in my practice. The social position of the patient, and certain other considerations, rendered it necessary that I should do more than is usually required of the medical attendant. The case was a well-marked one of septicæmia, and ultimately terminated fatally. I watched the case very closely for ten or eleven days; and twice daily, with my own hands, washed out the vagina with a disinfectant solution, and dressed a vulvar ulcer which had formed. Being at the time on duty at the Royal Maternity Hospital, and satisfied in my own mind that my disinfectant applications were sufficient to prevent any harm to my patients, I continued my services there. It so happened, that during these ten days there were several specially interesting cases treated in the Maternity. Accordingly, I had to perform craniotomy on an out-patient for obstructed labour. The operation was tolerably difficult, and took up considerable time. The patient never had a bad symptom, and made an excellent and rapid recovery. I also had occasion to employ forceps in a case in the hospital in which the head was arrested high up. That patient also presented no febrile symptoms, and recovered uninterruptedly. I likewise performed version in another case, in which the head and arm presented. This patient, like the rest, did well. In consultation I saw and examined a patient suffering from hæmorrhage after abortion. In this case I passed my finger into the interior of the body of the uterus, to make certain that no portion of membranes had remained behind. No bad symptom of any kind followed this manœuvre.

Had the remotest bad symptom appeared in the first case, I certainly should have at once

desisted. But the success in it emboldened me more and more to trust to the disinfectant measures I had adopted. Besides, I had before me the experience of Dr. Thos. Keith, in his statement that with due attention to antiseptics he felt at liberty to perform an ovariectomy operation, although half an hour previously he had had his hands in the filthiest mess possible.

When called to treat such cases, however, it is my invariable rule to attend to the strictest antiseptic measures. If I have to examine or lift a patient suffering from puerperal septicæmia, I always take off my coat and roll up my shirt-sleeves. After doing this, I wash my hands in turpentine or rub them with carbolic oil. After examining the patient I again wash my hands, and, if need be, arms, in turpentine and soap and water, using the nail-brush freely. Then I wash my hands in a five per cent. solution of carbolic acid, and finally pour a stream of running water over them from the tap. Considerable importance appears to me to be attached to the latter proceeding, as the running stream makes it certain that everything is carried away as well as washed off the hands. If a basin be employed, the hands are brought from time to time into contact with any septic matter that might remain undestroyed in the basin.

In common with every consultant obstetrician, I am from time to time summoned to see and examine cases of puerperal septicæmia with my professional brethren. I am in the habit of doing as I have indicated in such cases, and I am satisfied that thereby no harm has resulted to any of my own patients. Nothing could be further from my intention in this contribution than to inculcate carelessness or do anything which could bring danger to patients or disgrace to obstetricians. But, on the other hand, I am anxious that everything should be done for unfortunate patients suffering from puerperal septicæmia, which is consistent with fairness to the unaffected and to the obstetrician in charge.

I am further certain that the rules as to abstinence from seeing infectious cases, and as to suspension from professional duty so loudly preached by many heads of the profession,

are not acted upon by them. Indeed, I believe they are neither necessary, nor would they be effective for the purpose indicated. I agree entirely in the object, I disagree with the proposed means.

For aimless and haphazard suspension from professional duty, I would substitute the most thorough cleanliness and disinfection, believing that in the latter means the real safety of the patient lies. I have published my experience in this matter, in the hope that it may encourage others to trust to and practise disinfectant appliances in similar emergencies.

The principle of thorough, rapid, and complete disinfection ought also to be practised by nurses and midwives. If such measures were intelligently adopted, we should find less need to place nurses on a lengthened period of probation after attending a case of septicæmia than we do at present.

Their case is no doubt different from that of the medical attendant, if the latter restrict himself to his legitimate duty of superintending the nursing only. The intercourse of the nurse, and even of the professional midwife, with the patient, is more constant and more close than that of the doctor. But this fact only implies that the nurse and midwife should exercise greater care and thoroughness in disinfectant applications after attending a case of septicæmia. The disinfection should include both the clothes and person of the nurse. But, provided such measures are adopted, there appears no good ground for suspending a nurse for a series of weeks or months. Indeed, in the mere suspension there appears to be no real safety, as, unless measures of disinfection are duly adopted, it is impossible to say how long the person and clothes of a nurse may remain a source of danger. A very valuable contribution on this subject is made by Ahlfeld in the *Centralblatt für Gynäkologie*, 21st May, 1880. In this article the author protests against the State regulation adopted in Saxony, which compels a midwife, when a case of puerperal fever occurs in her practice, to cease from it for a stated period, instead of insisting upon rapid and thorough disinfection.

Diphtheria has caused from 30 to 65 deaths a week in New York for several months.

## Translations.

### TREATMENT OF SYPHILIS.

M. Martineau has made known, in some lectures published in the *Union Médicale*, the means he employs against Syphilis. The first year, for three or four months he prescribes mercury, followed for three or four months by the iodide of potash, then for two months mercury, and one month's rest.

The second year he prescribes one month mercury, two months iodide of potash, and two months rest; then again, one month mercury, three months iodide, and three months rest; during this last stage of rest he begins the sulphurous treatment. The third year of treatment is the same as the second year—one month mercury, two months iodide and three months rest. If after using as a touchstone a second sulphurous cure, new manifestations supervene, he recommences the treatment for the third year. This prolonged treatment is, according to M. Martineau, the sole means of preserving the patient from the visceral complications actually so frequent. He prescribes the iodide of potash from the first year, but always causes its administration to be preceded by that of mercury, observation having shown, he says, that its anti-syphilitic action can be aroused only after that produced by mercury. If tertiary manifestations resist large doses of the iodide of potash, cease the potassic medication, and for a few days give mercury; at the end of this time you will see the symptoms give way to the iodide. The sulphurous waters constitute an important auxiliary to the mercury by facilitating the elimination of this medicine, by accelerating its specific action, and by contributing to its toleration by the organism.

The recrudescences of syphilis being coincident usually with the renewing of the seasons, above all, with spring and autumn, M. Martineau chooses these periods to take up again the mercurial treatment, or to increase the dose of mercury, or of the iodide of potash.

M. Martineau does not prescribe mercury at the time of the chancre's appearance, but only at the beginning of the secondary symptoms.



This is at least prudent when the diagnosis of the indurated chancre is not perfectly clear. It would doubtless be no indifferent matter to cause a patient, in spite of himself, to undergo for three years M. Martineau's treatment for being guilty of a soft chancre.

M. Martineau prefers to administer mercury by the mouth, and he prefers Sédillot's pills—one pill the first week, two for six weeks, then one for the following months. In the course of the second year he gives a teaspoonful a day of Van Swieten's liquor, or a Dupuytren's pill. M. Martineau indicates many formulæ for Van Swieten's liquor. Here is that of M. Mauriac:

Distilled water .....	550 grammes.
Syrup of morphine .....	250 "
Orange flower water ...	100 "
Tincture of mint .....	4 "
Rectified spirit .....	95 "
Sublimate .....	1 "

One teaspoonful in a cup of milk.

For Dupuytren's pills the physician of Lourcine usually employs the following formula:

Bichloride of mercury ...	0.005 grammes,
Extract of opium .....	0.01 "

for one pill, to be taken before breakfast.

The iodide of potash is likewise administered in moderate doses of 50 centigrammes to 1 gramme a day. Here is the formula usually employed:

Distilled water .....	400 grammes.
Iodide of potash .....	40 "

One to two teaspoonfuls at night in half a wine glass of water, sweetened with syrup of bitter orange peel.

The sulphides, the third therapeutic agent in syphilis, ought to be employed from the end of the second year. If the patients cannot betake themselves to some mineral station, he prescribes sulphur baths, and to drink for fifteen days of each month, and this for about three months, Challes water, sulphurous bromo-iodide water, in the dose of half a glass morning and evening, mixed or not with milk. The sulphurous water facilitates the absorption and the elimination of mercury, permits of its being given in large doses without provoking mercurial stomatitis, and even combats this last as efficaciously as chlorate of potash.

A tonic and reconstituant regimen and a

severe hygiene are indispensable. M. Martineau greatly appreciates the effects of *café nègre* taken in the form of wine elixir or infusion. When there exists a rapidly threatening visceral lesion, he orders frictions of Neapolitan ointment, or subcutaneous injections of biniodide of mercury.

In infantile syphilis mercurial frictions are employed with advantage—one gramme of ointment a day, or Van Swieten's liquor, half a teaspoonful mixed in the milk of the feeding bottle, unless the medicine is made to pass through the milk of the nurse. The mercurial treatment is followed by the iodide of potash, 20 to 50 centigrammes a day for two or three months. This treatment is continued for two years, at the end of which time they may take every day for a fortnight, one to two table-spoonfuls of Challes water.—*La France Méd.*

#### PATHOGENY OF THE ICTERUS OF NEWLY-BORN CHILDREN.

In a recent work, Dr. Ribell after having described the parti-coloured aspect of the skin of the infant during the first days that follow its birth, either that it may disappear promptly, or that it may endure for many weeks or even for many months, or that, more tenacious still, it persists until the death of the child succumbing to marasmus or carried away by some acute affection, passes in review the different theories emitted to explain the icterus of the new-born.

Admitting only the icterus from biliary retention, and that from modifications supervening in the elements of the blood liquid under an undetermined morbid influence, he absolutely rejects icterus from cutaneous congestion or generalized ecchymosis.

To the author, the disease presents itself under three forms: 1st, simple icterus, which may be at once bilious and hematic, with a colouration of variable intensity and of short duration. It appears the first or second day after birth, to disappear twenty-four or forty-eight hours later. The urine presents the green reaction with nitric acid only if the icterus is general. 2nd. The second form is nothing else than hematic icterus, characterized by a yellow colouration, in general not deep, although

there exist numerous varieties of it: yellowish-red or amber-yellow reaction of the urine with nitric acid. 3rd. Lastly, the icterus symptomatic of an hepatic affection: it is the parenchyma itself of the liver which is attacked. But it is necessary to distinguish between affections with a rapid progress in which icterus is frequent, such as cirrhosis, cancer and stenosis, and affections that progress slowly like the active and passive hyperæmias.

Although the author may not as yet draw a definitive conclusion from his researches, still, if one reflects an instant, says he, on the profound modification that the hepatic circulation undergoes at the moment of birth, as well as of the composition of the blood liquid, we shall be convinced of the frequent possibility of the production of icterus, and we cannot do less than consider these physiological modifications as the veritable pathogenic cause of this affection in the new-born. If to these causes we add the inconveniences, to the fœtus, of a laborious accouchement, of an accident experienced by the mother during gestation—as for instance, a fall, an external violence, or even an inflammation of one of the elements of the cord—we are obliged to admit that the icterogenic process is complex and that its pathogeny is extremely variable.

It is in having regard to all these conditions that Dr. Ribell emits the following opinion, supported on many observations reported in his original memoir: 1st. That simple icterus, precocious or tardy, of the new-born is a hæmatic icterus, the hæmapheic of Gubler. 2nd. That the grave icterus of the new-born is always a bilious icterus, symptomatic of a disease of the liver or of the biliary passages.—*Gaz. des Hôpitaux*.

#### CONTRIBUTION TO THE STUDY OF THE PASSAGE OF EMBOLI THROUGH A PATENT FORAMEN OVALE.

BY LITTEN.

At the autopsy of a woman, aged 43, who presented a gangrene of the right leg, the femoral artery and vein of that side were found obliterated by a thrombus, multiple emboli in both lungs, and older foci in the spleen and kidney, without being able to find any source of the emboli in the domain of the general circulation. Virchow, to whom the preparations were submitted, found a thrombus in the right auricle and a permeable foramen ovale by which the embolus had been able to pass into the arteries.—*Lyon Méd.*

### Correspondence.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

SIR,—I was a good deal surprised at your account of the late case of Brodie vs. Scott, under the head of "Malpractice." Permit me to state that you have been grossly imposed upon by whatever informant you derived your information from (and it is not hard to guess who your informant was). I will now give you a true statement of the case for the sake of fair play, and also for the benefit of the profession. Mr. Brodie, in opening a bottle of Liq. Ammon. F. on the 10th of July last, received the vapour in his face, and *immediately* rushed out of the shop, where he was stopped by Mr. Frayne, who *immediately* called in Dr. Scott, whose shop was only about six rods off. The whole time from the accident to Dr. Scott's attendance was not *five minutes*, instead of fifteen or twenty, as you state. Dr. S. bathed his face, and gave him a large emetic dose of vin ipecac., helped him home, and ordered him milk. Next day (Sunday), I went to call upon Mr. B., not as a doctor, but as a friend. I met Dr. S. on my way, and had a chat with him, when he did not seem to regard the case as at all critical. On my arrival, about twelve o'clock, I found Mr. B. propped up in bed, *gasping for breath*, respiration at least 80 or 90. The only means I have, of course, of timing the respiration was breathing in a similar manner myself afterwards, and taking the time then. I immediately sent for Dr. Hutton, with instructions to bring acetic acid with him. The messenger on the way met Dr. Boyd, and brought him along too. In the meantime I had applied large mustard plasters. When Drs. H. and B. arrived, I applied the acetic acid on a handkerchief, and the effect was *instantaneous*. Within 10 seconds the respiration fell to 32. All these *facts* can be sworn to by us three medical men, and by others present. His fingers at this time were blue up to the second joint. We then gave drinks of lemonade and acetic acid, and he became comparatively easy. Within an hour of the first application of the acetic acid the blueness began to go down, was down to the finger nails at night, and had disappeared altogether next morning, when



he partook of a little beef tea; and as he had drank large quantities of milk the night before, showed no signs of exhaustion. The respiration fell to 20 towards evening, and he had a very fair night's rest. On Monday morning he had two severe spasms, followed by coughing up what seemed to be thickened mucus. I was not present at the time. The occasional use of the acetic acid was kept up. On Monday evening, the spasms showing signs of returning, we administered Tinct. Benzoin Co., combined with Chloral Hyd., by means of a steam atomizer, which always gave immediate relief. I soon found, however, that the Tinct. B. Co. clogged the instrument, and discontinued it, using the chloral alone. At his request I gave him a dose of Hydrarg Submur., grs. x, and the bowels not being moved, I gave an injection on Tuesday morning, which operated well, and he was perfectly regular in his evacuations ever afterwards. Tuesday he passed comfortably, having slight spasms from time to time, which yielded promptly to the chloral. On calling on Wednesday morning, the attendant informed me that the chloral didn't seem to have as good an effect, and I noticed that his breath had become foetid. Suspecting gangrene, I at once added a little carbolic acid to the inhalation, which he said gave him great relief. I was then called away to the country, and saw him no more alive. He died about 11.30. A similar statement to this, signed by Drs. Hutton, Boyd and myself, has been in Mrs. Brodie's lawyers' hands these three months. Further, a case occurred last summer, within 10 miles of here, where a bottle, containing 5lbs. of Liq. Ammon. F., exploded in the hands of Dr. Cornell's clerk, only about 1lb. remaining in the bottle. The clerk was affected *precisely* as Mr. B. was. Dr. Cornell used the acetic acid at once, the patient being immediately relieved, and able to return to his work within a week, the delay being caused by one of his eyes being badly inflamed. Now, you further state that Mr. B. "was at all times a delicate man." I am ready to swear (and so is every man who was intimately acquainted with him) that he was possessed of a very hardy, rugged constitution, and of very regular habits. In my seven years of intimacy with him, I never knew him

sick but once, and that was only a mere trifle. Now, with regard to the withdrawal of the charge on account of the witnesses, &c., I will merely state that *all the witnesses* for the prosecution, with *one* exception, were anxious for the case to go on; and it was withdrawn, I am given to understand, without even the consent of the plaintiff. All the medical witnesses (with one exception) for the prosecution were ready to swear (to the best of their belief) that the man's life would have been saved if the acetic acid had been used at first. The doctors employed by the defendant went on the *theory* that all the ammonia had escaped after the lapse of eighteen hours. Apparently a very good *theory*, but how then will they account for the instantaneous relief given by the acetic acid? If the membrane had been destroyed, the acetic acid would have had no effect, good or bad; its having such direct effect, proves evidently that the ammonia had *not* left the system. So much for theory. For my part, I have little doubt that had the case gone on the plaintiff would have got a verdict, as nothing could excuse the patient being left *without* antidotal treatment for eighteen hours. As it is, the case stands thus: The defendant is wealthy (by marriage). The plaintiff is a widow in almost destitute circumstances, and I understand the case will be brought up again if she can raise the means. If not, it will not be the "*iniquity*" of the cause, but the poverty of the plaintiff, that will prevent the matter being thoroughly ventilated. The defence being that the case would have terminated fatally any way, and no medical man on *either* side pretending that proper antidotal treatment had been used for eighteen hours, I think the defendant has very little reason to complain. In conclusion, I will merely state that I have no interest whatever in the case, except that of a sincere love of fair play; nor would I have now used my pen had I not found the conduct of a *highly estimable lady* (in every sense of the expression) stigmatized as "*iniquitous*." With all due apologies for trespassing so far upon your valuable time,

I remain,

H. J. NASH,

L.M.B. & M.C.P. & S., Ont.

Forest, Dec. 7th, 1880.

P.S.—With regard to your remarks about altering the law, the only alteration that would bear upon the case would be to make the plaintiff give security for both costs before entering action, which would shut the gates of justice forever against the poor, and give *carte blanche* to ignorance and negligence to play with human life *ad libitum*.

## A LETTER FROM LONDON.

## SURGICAL NOTES.

MR. EDITOR: SIR,—It is generally acknowledged that Mr. Jonathan Hutchinson is "the best all-round man" in London, as the saying goes. His manner of speaking is very quiet, but his views are expressed with great clearness and conciseness; at the same time there is the greatest candour, and no evidence of professional pride or obtrusive *egoism*. Jonathan Hutchinson's style and manner—in fact the entire demeanour of the man—is a rebuke to the self-important, dogmatic, assertive class of medical practitioners. He is not ashamed to say before a class of medical students, "I do not know exactly what is the state of matters in this case." It has seemed to me, Mr. Editor, that this eminent surgeon's views on any matter must be of great interest to your readers in Canada.

Mr. Hutchinson most explicitly stated his belief that *erysipelas is not a specific fever*. Some surgeon, not resident in London, first expressed this opinion, at least in England; but the school adopting this view of the disease is still a small one, and, as is well known, the majority of text-books on surgery adopt a contrary theory. Mr. Hutchinson's definition of *erysipelas* is, "An inflammation characterized by pitting, and vesication, with a definite outline, which has a strong tendency to shift its position." It is contagious, and arises *de novo*. Local treatment by poultices is condemned; a lead and spirit lotion which Mr. H. is very fond of being preferred. Great stress was laid upon the statement that *erysipelas* has *no period of incubation*. Most of your readers will probably think as I do, that a good deal might be said on both sides of the argument; however, the fact that I have witnessed time and again that *erysipelas* can be arrested or aborted certainly seems to militate against the view that it is a specific fever.

Mr. Hutchinson's views on transverse fracture of the patella also struck me as at variance with the common teaching on this subject. They may be summarized thus: The greatest danger is from separation of the fragments by *effusion*. "There is no spasm of the quadriceps

extensor." There is no special advantage in bony union, provided the fibrous or semi-osseous union be firm, as it generally is. The treatment is to be directed specially to getting rid of the effusion. A very striking example of *unilateral atrophy of the face* was presented at the afternoon Clinic of the London Hospital, of which Mr. Hutchinson is the principal surgeon. The individual who was such a clinical curiosity had exhibited himself to many distinguished men in Europe, and had numerous photographs of himself in different positions.

The affection began at nine years of age, and affected not only the muscles, which were much atrophied, but also the bones and the half of the tongue on the affected side; so that this organ, when protruded, pointed very decidedly to the affected side. Mr. H. supposed that this atrophy had been subsequent to Addison's cheloid.

An admirable example of the latter was at that time in the wards.

Mr. Hutchinson's views on Addison's cheloid, or, as he would prefer to name the disease, morphœa, may be stated in brief: It is *allied* to herpes, being due to some affection of the nerves. Neither herpes nor morphœa occurs in young infants; both follow the course of nerves. Morphœa is due probably to inflammation of the vaso-motor filaments, and is characterized by oval patches of indurated whitish tissue, as though "infiltrated with lard or inlaid with ivory." On the very same day that the middle-aged man with atrophy of the face appeared, a young woman was also shown with well-marked *hypertrophy of the temporal and masseter muscles* on both sides. This patient's general health was excellent, as her appearance indicated, and no special cause could be assigned for the deformity. Mr. H. suggested that this was probably an example of an hypertrophy due to a state of the vaso-motor nerves directly the opposite to that of morphœa, giving rise to *dilatation* instead of contraction of the vessels of the part. On skin diseases and syphilis Mr. Hutchinson is considered to have no peer in England. But the latter subject has been by no means exhausted even by Mr. Hutchinson's extensive observations, for Dr. Thomas Barlow, of the Children's Hospital,



believes that *craniotabes* is much more frequently associated with syphilis (hereditary) than with rickets. This is an observation of great value, and one not yet recognized, I think, by writers on syphilis. As Dr. Barlow's *clinique* is very extensive, his observations must be accepted as reliable and of very great value. Thus far I have noted in Mr. Hutchinson's remarks the following points of interest in connection with syphilis:

(1.) Syphilis detects any peculiarities or weaknesses of the patient. A relapse of a secondary rash with a tendency to ulceration in a young man with feeble constitution, Mr. H. considered as illustrating this proposition.

(2.) *The Treatment of Syphilis*.—Mercury in the second stage; iodide of potassium, or the latter with bichloride of mercury, in the third stage, or so-called tertiary syphilis, which should be considered rather as the sequelæ of syphilis than a distinct stage.

If there is any want of tone in a particular case mercury may be combined with tonics, especially with iron. "I never combine mercury with quinine or bark;" it prevents the action of the principal remedy, as is illustrated by the fact that quinine will prevent salivation.

Yours truly,

T. W. M.

ONE OUTCOME OF THE NURSING DIFFICULTY AT GUY'S.—On the conclusion of their Clinical lectures in November, Dr. S. O. Habershon, senior physician, and Mr. Cooper Foster, senior surgeon, of Guy's Hospital, tendered their resignations, which were accepted by the governors. We wonder what the public opinion will be of a body of men who could thus prefer to retain the services of a matron, whose presence in the Hospital has been a source of discord only, to those of such able and distinguished servitors as the past forty years of Guy's Hospital's history have proved Samuel Habershon and Cooper Foster to have been. Dr. Hilton Fagge and Mr. Davies Colley have been elected to the vacant posts.

ACUTE ICTERUS FROM PRESSURE.—Litten reports in the *Charité Annalen*, Band V., the history of the case of a woman, 37 years old, in whom repeated attacks of intense icterus were produced by the pressure on the gall bladder of a movable kidney.—*Brit. Med. Jour.*

## THE CANADIAN Journal of Medical Science,

A Monthly Journal of Medical Science, Criticism,  
and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, JANUARY, 1881.

### MATRICULATION EXAMINATION FOR THE ONTARIO MEDICAL COUNCIL.

When it was decided at the last meeting of the Ontario Medical Council to substitute the Provincial Intermediate High School Examination for the Matriculation Examination, as held under the previously existing regulations, we believe it was a source of satisfaction to the majority of medical men in the Province. The history of our Collegiate Institutes and High Schools during the last few years has been somewhat remarkable. They have advanced with such amazing rapidity that we can scarcely recognize them as the old Grammar Schools of Ontario. They show their efficiency by the thorough training they give their students, as we may see by their standing at the various Examinations they are called upon to pass, including those of the Professions, and the various Universities. While looking with pride upon the marvellous growth of these most important Educational Institutions, we can fully appreciate the wisdom of the Council in choosing their Intermediate Examination as the portal through which young men must pass before engaging in the important studies of the Medical Profession. In considering the quality of any Examination, we can never judge simply by the number of the subjects prescribed. We must take into view the standing of the Examiners, the nature of the questions, and the percentage required. The thoroughness, correctness, and impartiality of this Examination are beyond question; and its severity is proved by the large proportion of the unfor-

fortunate "plucked" candidates. Its standard is high—we believe higher than the average on this Continent or in Great Britain. We fully realize the importance of this statement, and before making it have instituted a careful study and comparison.

The Council have not, however, accepted the Intermediate as it stands, but have made some additions to that Examination, which make it very inconvenient, and in some cases impossible, for the High School Teachers to prepare their pupils for matriculation. The original resolution, as proposed by Dr. Burns, reads as follows: "Moved, that on and after July 1st, 1881, in lieu of the Matriculation Examination heretofore in force, the Council accept the Provincial Intermediate High School Examination, with Latin included as a compulsory subject, and that upon presentation of the official certificate of having passed the said Examination to the Registrar, and the payment of fees, the holder of the same shall be entitled to register as a medical student." We had supposed that this resolution, after coming under the consideration of the Educational Committee, was passed by the Council, but on examining their announcement we find the important additions above referred to. Some of our readers may wonder at our reference to these "additions," when no subjects are specified which are not included in the ordinary curriculum of the High Schools; and we will endeavour to explain our meaning.

The subjects of the Intermediate Examination include three compulsory groups, as follows:—

- |            |   |  |
|------------|---|--|
| Group I.   | { | Arithmetic,<br>Algebra,<br>Euclid.             |
| Group II.  | { | English Grammar,<br>Composition,<br>Dictation. |
| Group III. | { | History,<br>Geography,<br>English Literature.  |

Every candidate is compelled to take these nine subjects, and in addition to these, there are four optional departments, of which he must choose one. It is also expressly stated that "no candidate will be allowed to take more than one of the four optional departments."

1st Optional Department:

- |           |   |  |
|-----------|---|--|
| Group IV. | { | Natural Philosophy,<br>Chemistry,<br>Book-keeping. |
|-----------|---|--|

2nd Optional Department: Latin.

3rd Optional Department: French.

4th Optional Department: German.

The Council have not only decided on the nine compulsory subjects, and chosen from the optional departments that of Latin, but have also totally ignored the regulation quoted above, and have added all the optional departments, leaving only a choice between French and German. We cannot help thinking that this has been done inadvertently, without fully appreciating the results of such a course.

We have taken considerable pains to enquire at the Education Office in Toronto, and to communicate with some High School Inspectors and Teachers throughout the Province, and find that, with their existing regulations, it is impossible to prepare students in all these subjects without extra work after the completion of their ordinary duties. The reason is this: the compulsory subjects are taught at different hours, so that every pupil may receive instruction in them, but the optional subjects are taught "concurrently," that is, at the same hour. It is thus impossible for the students to receive instruction in more than one of the optional subjects according to the present arrangement of their time-tables. It must be remembered that the larger High Schools are institutions of considerable magnitude, having large staffs of teachers, and it is no trifling matter, when they have made their arrangements to suit the ordinary Intermediate and University Examinations, to ask them to make the radical changes here indicated. We may say that those to whom we referred spoke in the most kindly way of the new regulation, and expressed their anxiety to do all in their power to accommodate the wishes of the Medical Council. It was thought by some that they might manage to teach both Latin and Natural Philosophy, but entirely impossible to teach all the optional subjects without adding many hours in the week to their already very laborious duties. Some of the Masters have expressed their intention of undertaking this



extra work, if it be required; while others say they are unable to do so, and will be compelled to refuse to prepare any pupils for the Examination. The candidates attending the latter Schools will be compelled to take the ordinary work as laid down in the programme, and look elsewhere for instruction in the extra subjects. Let us glance at these extra-subjects demanded by the Council: French or German, Chemistry, Book-keeping and Natural Philosophy. Surely, all will admit that in the aggregate they constitute a very formidable addition to an already severe examination. It is almost equivalent to fixing a standard equal to a university degree. We hope that before very long it will be considered advisable to ask candidates for medicine to take a course in Arts, but the time for this has not yet arrived. It is well to be an accomplished linguist, but we do not consider a knowledge of French or German an absolute necessity for the medical student. There is no more reason why Chemistry should be demanded than the other primary subjects, such as Anatomy, Physiology and Materia Medica. We approach the subject of Book-keeping with considerable diffidence, as we labour under the disadvantage of not possessing a minute knowledge of the intricacies of double or treble entry. Not knowing what the result of such ignorance may be, we will venture no opinion, but leave the subject to those who are competent to discuss it. Every medical student should have a fair knowledge of Natural Philosophy; but as it is one of the subjects taught in our Common Schools, we might presume that such knowledge is possessed by those able to pass the Intermediate Examination. However, if the Council be desirous of examining candidates on this subject, the High Schools and Collegiate Institutes might be able to make such arrangements as would allow the pupils to take both Latin and Natural Philosophy.

We must, after all, return to our formerly expressed opinion that it is simply an oversight. In the College announcement the words are, "the High School Intermediate Examination, with Latin included." In the original resolution, as proposed in the Council, the words are, "the Provincial Intermediate High School Ex-

amination, with Latin included as a compulsory subject." This surely includes only the ordinary compulsory subjects, and Latin among the optional: the Council making the choice of the latter, instead of leaving such choice to the candidate. If such were not the intention of Dr. Burns and Dr. MacDonald, as shown by their remarks when moving and seconding the resolution, we very seriously misunderstood them. The mistake appears to have occurred in making the addition to Regulation 5, before referred to, which (addition) commences as follows: "The said Examination to embrace the following subjects," &c.; the subjects named being those before mentioned.

We are in a position to state that this mistake (supposing it to be such) has caused much perplexity and anxiety to both High School teachers and students, and we hope it will be rectified as soon as possible. With this end in view, we would ask the Executive Committee to consider the question at their first meeting, and, if our views are right, correct the error, and at once inform the High School Teachers of their decision.

SHUTTLEWORTH'S FLUID EXTRACTS, &c.—We are pleased to learn that our friends in the city find Mr. Shuttleworth's Fluid Extracts very reliable, and are now using them largely. This is more especially true with reference to his preparation of ergot. With so many uncertain specimens of this drug in the market, it is very important to obtain one that is thoroughly trustworthy, and we therefore cheerfully recommend all practitioners to try Mr. Shuttleworth's preparation. In addition to his Extracts, he has a large variety of new remedies—pure chloroform, and all kinds of McKesson and Robbins' gelatine-coated pills.

PERSONAL.—We are pleased to observe that Dr. H. H. Wright, who has been for some time past in ill-health, and latterly confined by iritis to a darkened room, is again about. We congratulate our old preceptor most sincerely upon his emancipation from the thralldom of an enforced inaction, which, in one of his mental activity and untiring energy, speedily consumes the zest of life.

## FRATERNITY.

How good a thing it would be if brethren would only dwell together in unity! But, alas! the communication published in another column, from Dr. Nash, of Forest, very plainly proves that such a consummation, so long and so devoutly wished, still "misses the flower of its accomplishment."

The letter, too, discloses the persistence in our midst of an evil which has been the subject of a thousand homilies by the censors of the profession; and abundantly bears witness to the already well-established fact that ill-feeling, jealousy and spleen amongst members of the profession are the potent cause of malpractice suits, and that wherever such actions are rife, "envy, hatred, malice, and all uncharitableness" likewise abound. Dr. Nash is entirely mistaken in supposing that we have derived our information from a biased source. Our notice of the case of Brodie vs. Scott was published entirely in the interest of the profession, and not at all in that of Dr. Scott, who is neither a subscriber, nor in any sense a friend, to this Journal.

With reference to Dr. Nash's friendly call upon Dr. Scott's patient, we would venture to remark that it is, in our opinion, highly undesirable for medical men to do more than leave a card of kind enquiry at the house of a sick friend, who is at the time under the actual care and attendance of another practitioner, since the stigma of suspicion will attach to the cleanest skirts, and patients too often ask awkward questions even unintentionally; and the manner of receiving these, whether answered or avoided, is over apt to impress their lay perceptions with a seeming censure of the practice to which they have been submitted. We are clear, therefore, that had Dr. Nash not visited Brodie, no action would have arisen. But Dr. Nash does not in this case claim the extenuating consideration of being trapped into a condemnation of the treatment, and, in truth, we can discover no reason why we should extend it to him, since he voluntarily states that finding the patient "gasping for breath," and yet breathing "at least 80 or 90 times" in the minute, he immediately sent for Dr. Hutton and acetic acid. But why, we would ask, did

he not send for Dr. Scott, as the canons of our etiquette direct? In the meantime Dr. Nash had applied mustard plasters, but whether to the patient (and if so, to what part,) or to the empty ammonia bottle (as our forefathers did) our correspondent deposes not. On the arrival of Drs. Hutton and Boyd, the acetic acid was applied on a handkerchief, but where to is not stated; suffice it, however, that "the effect (relief?) was instantaneous," and that "within 10 seconds the respiration fell to 32."

Now, we would like to be informed as to what was, in the opinion of these gentlemen, the cause of the excessive frequency of respiration (at least, 80 to 90 per minute) at the time, according to Nash's statement, some 18 hours after the inhalation of the ammonia; and what is the explanation of the marvellous fall to 32 within 10 seconds? The disappearance of the cyanosis was only in keeping with what had gone before; as was also the extraordinary tolerance of the patient's stomach for milk curd, since he was able to imbibe, at frequent intervals on the same evening, copious draughts of lemonade and acetic acid, and large quantities of milk. But the most marvellous feat recorded by Dr. Nash in his account is the interlarding of a day (which he omits to name otherwise than by the denomination "next,") between Sunday and Monday, and so prolonging the patient's life by 24 hours at least. When the spasms returned on Monday evening, however, the acetic acid, which had before proved so exceedingly beneficial, was now abandoned, for reasons withheld, and its place supplied by pulverizations of Tr. Benzoin Co. and Chloral Hydrate. This, too, always gave immediate relief, notwithstanding that the Benzoin clogged the apparatus—a circumstance not altogether unfavourable, we opine, to the denuded mucous membrane. Did the Benzoin and Chloral likewise act as antidotes to the caustic alkali?

We must commend to the notice, but not to the imitation, of our readers, Dr. Nash's ingenious and superlatively accurate method of counting a patient's respiration. We can scarcely credit the doctor when he says that he is prepared to attest under oath the accuracy of observations made in such a haphazard manner.



Certainly it would demand as much elasticity of conscience on his part, as of credulity in his auditors.

Now with reference to the antidotal treatment of ammonia poisoning. Acids have, of course, been found beneficial as neutralizants in the case of ingestion or topical application of the other caustic alkalies, and also in some few cases of ammonia poisoning, but their employment needs to be instantaneous, and more especially so in the case of the volatile alkali; since the destructive effects of these caustics is so rapidly accomplished, and ammonia is so speedily volatilized. The authorities, however, do not contain the record of improvement following the use of acids in cases of ammonia inhalation after the lapse of any appreciable time, to say nothing of a few hours; and common sense rebels against the acceptance of the view that a neutralizing effect could be manifested after the expiry of 18 hours. Spasm of the glottis is oftentimes induced by the inhalation of ammonia, and indeed death has thus resulted from its application to the nostrils in cases of faint; but it must be exceedingly rare that any of the vapour finds access to the lungs, since the sole portal of entry is by its irritant effects immediately closed. Supposing, however, that in this case the vapour did find its way into the lungs, inflammation of the bronchial and vesicular mucous membrane wherever touched must have ensued, but we entirely fail to find the signs and symptoms of such a complication in Dr. Nash's report of the case after it came into his hands. We are, therefore, constrained to ask the question: Of what did the patient die? And why did not the initial improvement manifested on the change of medical attendant continue? Did the man die in consequence of Dr. Nash's visit to the country? Why was not a *post-mortem* made to determine the cause of death?

With reference, in conclusion, to our correspondent's connection with the case, we have only to say, in brief, that, in our judgment, the course alleged by Dr. Nash to have been pursued throughout, by himself and associates, demands the severest censure that can be imposed upon it. We have faith, and doubt not that the sense of justice and propriety which

pervades the great body of the profession will not fail in its infliction.

That the action can be entered again (or any number of times with the same result) is only too true, and we feel it our duty to strenuously urge upon each individual practitioner in the Province the necessity of using his utmost influence, great or small, with our legislators on the floor of Parliament to promote the statutory imposition of some reasonable restriction of the limits of such vexatious, expensive, and, in the majority of cases, idle litigation.

#### ANNUAL DINNER OF TRINITY MEDICAL SCHOOL.

We are very glad that the custom of having an annual dinner in connection with each of the Schools of Medicine in Toronto has become thoroughly established. Of the various forms of social reunions, we know none better than this, as it not only brings the teachers and students together in a pleasant social way, but both are brought in contact with all classes of citizens, who are represented at these dinners by a large number of our most prominent men. We are convinced that much good has been, and will continue to be, accomplished by these annual gatherings. The public have discovered that the medical students are not simply a lot of noisy, boisterous schoolboys, but, as a rule, are a body of thoughtful, intelligent men, who, when brought in contact with their professors and the public, are able to conduct their proceedings, not only "in decency and order," but also with marked ability.

The Trinity School dinner, which was held at the Rossin House on the 25th November, was a pronounced success. The guests were numerous—the members of the Faculty were all present. Many of the graduates were on hand—not enough, however. The students made up for the deficiency in the number of the grads by turning out in full force, thus showing their loyalty to the School and its Faculty. The dinner was one of Mr. Irish's best: we can give it no higher praise. Mr. Baugh acted as Chairman, and Messrs. Krauss and O'Reilly as Vice-Chairmen, and the success of the entertainment was to a large extent due

to the ability displayed by them in conducting the proceedings.

It is now well known that cold water, tea or coffee are the only beverages at these dinners. A "cold water dinner" has not been a popular institution in the past, but the medical students have proved during these last few years that such a dinner can be made a thorough success in every sense of the word. His Worship the Mayor gazed with pride on his glass of clear, untainted city water, which he held up for the inspection of the company while responding for the Corporation. Some of those present "couldn't see it," but that was, no doubt, due to its transparency. The Chairman, 1st Vice-Chairman, Mr. Lauder, M.P.P., Prof. Pernet, and others, spoke in pleasing terms of the cordial good feeling which existed between the Trinity Medical School and its rivals; and Dr. Thorburn, the representative of the Toronto School, on rising to reply to the toast of the "Sister Institutions," was received with a perfect storm of applause from the students, showing the reality of this friendly feeling towards his School, and their appreciation of his own well-known popularity.

The Chancellor of Trinity University, Hon. G. W. Allan, in his response, congratulated the Trinity School on its success, and spoke in a most kindly way of the medical profession. Dr. Geikie, Dean of the Faculty, expressed his pleasure in meeting the guests, graduates, and students. He alluded in happy terms to the success of the School, and the efforts of the Medical Council to advance the interests of the profession in every possible way.

Dr. Stark, of Hamilton, responded for the graduates, and Messrs. Ferguson and Kennedy for the undergrads. Prof. Goldwin Smith, who was present, received, as he always does, a warm welcome from the students; but objections are frequently raised about the length of his speeches, as he will persist in "cutting them too short." Dr. O'Reilly and Mr. Gillespie responded for the "Toronto General Hospital." Among the other speakers were Drs. Allison and Burns, Prof. Pike, and Rev. Mr. Rainsford.

Among the most pleasing features of the evening's entertainment was the really excellent singing of the students' quartette, Messrs. Fairchild, Gaviller, Jenner and Handbridge, assisted by Dr. A. J. Geikie, who presided at the piano. The dinner was concluded at a "seasonable" hour, and the general feeling was "happy to meet, sorry to part, happy to meet again."

## AN ADMONITION TO OUR LAY CONTEMPORARIES.

Sometime about the beginning of December, we were surprised to observe in both our morning dailies the announcement in a conspicuous place of the fact that Dr. Alt had removed to St. Louis, and that Dr. Ryerson had succeeded to his appointments here. We noted at the time that the two announcements in the different papers were *verbatim ac literatim* "counterfeit presentments." Again, on the morning of the 11th December, the *Mail* contains the same announcement in its column of the city news; and *à propos* of this we desire to point out to the editors of our lay contemporaries the desirability of exercising a close supervision over the authorship of such announcements, which generally emanate from the misguided zeal of some lay friend, and always offend the upholders of professional proprieties. We, of course, at once acquit Dr. Ryerson of all knowledge of, or complicity in, these paragraphs; for even if he were capable of treading the highway to professional success through the columns of the daily press—which we do not believe—yet here the fact that Dr. Ryerson succeeded to Dr. Alt's appointments more than six months ago, proves that the author of the paragraph knew not whereof he wrote. We shall join most heartily with our professional contemporary in the endeavour to suppress this species of tradesman-like advertisement, before which every sense of professional etiquette and scientific modesty recoils in disgust.

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Alfred Hudson, M.D., Physician in Ordinary to the Queen in Ireland, last born and latest left of that illustrious triad—Graves, Stokes, and Hudson—in whose hands the lamp of medical science erstwhile burned so brilliantly in Dublin, passed over to the majority on the 19th November last, in the 73rd year of his age.

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CANADIANS ABROAD.—Edwin F. Hatton, of the Toronto school, passed the Primary Examination of the Royal College of Surgeons of England on the 9th of November. John E. Shaw, Chatham, Ont.; Eyre M. Thuresson, Ancaster, Ont.; William J. Cross, Barrie, Ont.; and James A. Todd, Barrie, Ont., were admitted L.R.C.P. and L.R.C.S., Edin., in November.



## PERSONAL.

Dr. J. P. Lynn, who has lately removed to this city from Ottawa, received an eulogistic address from the Rideau and Bathurst Medical Association. The address was signed by Drs. Grant, Sweetland, and 130 others. Dr. Lynn has been 20 years in practice; has been Coroner and Health Officer in Ottawa, and is an old and esteemed student of St. Michael's College, in Toronto.

MORAL INSANITY.—At the Canadian Institute, on the 11th ult., Dr. Joseph Workman read a very able and characteristic paper on this subject. Space will not allow us to do more than make a bare mention of the fact, in the hope that, if the paper be subsequently published, all our readers will make an effort to possess it. The subject is one upon which every medical man should hold a decided opinion, and be prepared with a reason for the faith that is in him. An imperfect synopsis appeared in the *Globe* of the 13th ult.

## WICKERSHEIMER'S PRESERVING FLUID :—

	For Injecting.	For Immersing.
Arsenious Acid..	16 grammes.	12 grammes.
Sodium Chloride .	80 “	60 “
Potas. Sulphate..	200 “	150 “
Potas. Nitrate ..	25 “	18 “
Potas. Carb. ....	20 “	15 “
Water .....	10 litres.	10 litres.
Glycerine .....	4 “	4 “
Wood Naphtha ..	$\frac{3}{4}$ “	$\frac{3}{4}$ “

—*Brit. Med. Jour.*

THE DIPLOMA MILLERS.—On Dec. 6th, the notorious “Dr.” (?) Buchanan the diploma-mill grinder, of Philadelphia, was fined \$500 and sentenced to ten months' imprisonment; Chapman, his accomplice, was fined \$500 and sentenced to a year and ten months' imprisonment. [We commiserate the fellow-prisoners of these rascals, and would suggest solitary confinement for them.—Ed.]

## Book Notices.

*Atresia of the Genital Passages of Women.* By EDWARD W. JENKS, M.D., LL.D., Chicago.

*Electricity in Medicine and Surgery.* By JOHN J. CALDWELL, M.D., Baltimore.

*The “Abdominal Method” of Singing and Breathing as a Cause of “Female Weaknesses.”* By CLIFTON E. WING, M.D., Boston.

*Report on Obstetrics*, read before Canada Medical Association, September, 1880, by Prof. WM. GARDNER, M.D., McGill.

*The Use of Electricity, Damiana, etc., in the Treatment of the Genito-Urinary Organs.* By JOHN J. CALDWELL, M.D., Baltimore, Maryland.

*The Electric Laryngoscope.* By A. WELLINGTON ADAMS, M.D., Colorado Springs, Colorado. Reprinted from “*Archives of Laryngology*, Vol. I., No. 3, September, 1880.

*Higher Education of Medical Men, and its Influence on the Profession and the Public.* Presidential address delivered before the American Academy of Medicine, 28th Sept., 1880. By F. D. LENTE, A.M., M.D. New York: Chas. L. Bermingham & Co., 1260 and 1262 Broadway.

*A Case of Combined Intrauterine and Abdominal Twin Pregnancy; the first child born naturally at 8 months; the second delivered alive at term by Laparotomy.* By H. P. C. WILSON, M.D., Baltimore. Reprinted from the *American Journal of Obstetrics*. New York: Wm. Wood & Co., 27 Great Jones St.

*Codman and Shurtleff's Catalogue, containing a Paper on the Inhalation of Atomized Fluids*, by H. BEIGEL, M.D. (*Lancet*); *on the Treatment of Chronic Diseases of the Lungs by the Inhalation of Atomized Fluids*, by MORRELL MACKENZIE, M.D. (*Med. Times and Gaz.*), and *on the Inhalation of Nebulized Fluids*, by J. SOLIS COHEN, M.D. Codman & Shurtleff, Boston; Lyman Bros. & Co., Toronto.

*Photographic Illustrations of Cutaneous Syphilis.* By GEO. H. FOX, A.M., M.D., Clin. Lect. on Dis. of Skin, Coll. Phys. and Surg., N.Y., &c., &c., &c. Forty-eight Plates from Life. Coloured by hand. Complete in 12 (monthly) Parts. New York: E. B. Treat, 757 Broadway.

We have received the first three numbers of this admirable Atlas, comprising plates of Syph. Erythematosum (3 plates), Pigmentatio Post Syph., Leucoderma Post Syph., Syph. Papulosum, Do. Lenticulare, Do. Miliare, Do. Squamosum (2 plates), Do. Circinatum, Syph. Papulo Squamosum, Syph. Papulo Pustulosum, and Syph. Pustulosum. All are of equal merit and exceptionally good. Each plate is accompanied by two quarto pages of letterpress, which all who are acquainted with Dr. Fox's fame as a Dermatologist, and his contributions to the subject, will look for and assimilate with avidity. The plates of "Cutaneous Syphilis" form a fit and necessary complement to the author's unrivalled "Photographic Illustrations of Skin Diseases," and should be possessed by all. For even those who eschew Dermatology as a whole, and have not large special Hospital advantages, cannot afford to be without any available means of recognizing the frequently puzzling and too often overlooked or misunderstood manifestations of that Protean and chameleon-like scourge which besets us on every side.

*The Orthopragms of the Spine—An Essay on the Curative Mechanisms Applicable to Spinal Curvature.* By ROBERT HEATHER BIGG, Assoc. Inst. C.E. London: J. & A. Churchill, 1880.

This little book of 149 pages is admirably written, in a clear and interesting style, and contains in its four chapters a most lucid exposition of the mechanical relation of the natural spine, the modes and causes of its deformation, and the means and methods of its restitution.

Chapter I. deals with the natural spine, whereof it contains an interesting mechanical view, which, however, need not detain us.

Chapter II. treats of the unnatural spine; and in it the author divides "curvature" into two classes, according to their causation, *intrinsic* and *extrinsic*—the former being determined "by the getting out of gear of the

spine itself as a piece of mechanism;" and the latter arising whenever "the spine itself, being structurally and functionally perfect, yet the discharge of its duties under altered circumstances (defect or deformity of other parts) of base or to be balanced mass, compels a consequent change of curves to accommodate the difference." The secondary or visceral symptoms of curvature receive a passing notice in this chapter.

Chapter III. enunciates the principles of reversion from unnatural to natural; affords a definition of the terms "orthopraxy" and "orthopragm;" and most unhesitatingly affirms that of all materials for orthopragmatic purposes steel easily bears off the palm.

The fourth and concluding chapter occupies just one-half of the book, and is devoted to the solution of the problems: "What are the holds the body is capable of affording to a spinal orthopragm? and these once secured, what forms of orthopragms are appropriate for the prevention or reversion of the varied types of spinal curvature?" We have not the slightest hesitation in referring our readers to the book itself for the answer to these questions, being persuaded that its persusal will be a source of interest and of profit alike to all. Suffice it for ourselves to say, that we do not believe that those who have had large experience of Sayre's Plaster Jacket will subscribe to the aspersions and the strictures cast upon it by the author. Of the typographical and material excellence of the publication itself, the names of the publishers render any mention superfluous.

*Medical Heresies.* By GONSALVO C. SMYTHE, A.M., M.D. Published by Presley Blakiston, 1012 Walnut Street, Philadelphia.

This is a small octavo of only 218 pages, but it contains much interesting and not a little amusing matter. The portion devoted to the early history of medicine is rather brief; but as the majority of medical readers care less for learning the infant state of their science than for useful information as to its modern progress, it is probable that they will not regret the brevity with which Dr. Smythe has dispensed of the doctors and dogmatists of antiquity and



the middle ages. In truth, it would appear that he has introduced this part as an appetizer to the more gustatory repast which he presents in the rest of his book. If there be in the present day any rational practitioner of medicine, or (if that be possible) any rational believer in the mysteries of Homœopathy, who desires to obtain a clear view of this wonder of our wondrous century, we can, with perfect sincerity, commend to his perusal Dr. Smythe's unpretentious little book. It is cleverly and forcibly written, and exhibits a very commendable minimum of those grammatical abnormalities and rhetorical excrescences which would appear to find a congenial soil in the great valley of the "Father of Waters," where not only a new variety of the Anglo-Saxon family is being rapidly evolutionized, but also a new and far less tight-laced dialect of the English tongue.

Dr. Smythe's exposition of the original wonders of the theory of Hahnemann, and of the *harmonies* of its present interpreters, is amusingly instructive, and cannot fail to edify all who feel a desire for more ample knowledge of this marvellous conception of human mentality. It would be more than sufficient to make the crumbled bones of Hahnemann shake in their decayed cerements, to hear, or even to dream of, the transmigrations and transformations which his inspired revelations have undergone within the past quarter of a century. The once happy family of his disciples is now split up into discordant anarchical sections, the majority of whom not only repudiate his most cherished and most potent dogma of the *infinite-simals*, but also question that of the *similibus*, whilst a very large percentage of them, if not indeed the whole fraternity, are either professed freebooters, or stealthy poachers, ready for bagging game on either side of the boundary, with either the popgun of their own battalion or the blunderbus of their antagonists, just as their dupes may prefer.

Great and graciously acceptable in all ages has *mystery* ever been; and let it not be said, as long as homœopathy lives, breathes, and fattens on human credulity, that our age is unworthy of association with any that has preceded it. Should any one question this asseveration,

we would simply ask him to read Dr. Smythe's little book: it will not cost him much, and he may read it leisurely, at little loss of time. When he gets through, he may not turn it to bad account by lending it to the first strong believer he chances to meet with, and watch the result.

But here we are reckoning without our host. It is one thing to lead a horse to the water, and quite another to get him to drink. We will now offer a bet, at large odds, that of the first twenty patronizers of homœopathy to whom any *so-called* allopathist will read a page of this book, reproducing even the very words of Hahnemann, or his modern interpreters, and drawing from them their inevitable deductions, he will be told by nineteen, as the writer of these lines has been by an earnest disciple, "*it's all lies*," yet this repudiator saw a homœopath dip the tip of his finger into a drop of some infinitesimal, and touch with it the navel of a baby yelling with colic, and cure it as quick as lightning. Great is mystery!

#### *Diseases of the Pharynx, Larynx, and Trachea.*

By MORELL MACKENZIE, M.D., London, Senior Physician to the Hospital for Diseases of the Throat and Chest, Lecturer on Diseases of the Throat at the London Hospital, &c., &c. New York: William Wood & Co.; Toronto: Willing & Williamson.

This is an age of specialties, and probably one of the worst abused of them all is that of the "Throat." Quackery has reaped rich harvests from this diminutive portion of the body during the last few years. The man who studies diligently this region, and at the same time knows but little about the system generally, should never presume to say he understands the treatment of "Diseases of the Throat." Such diseases are so often only the local manifestations of constitutional disorders that none but well-informed physicians, in the broadest sense of the term, should be trusted with their treatment. Of course we cannot object to the latter class paying special attention to the throat, or any other portion of the body, if they are so disposed, but we must protest against the abuse of specialties by superficial one-sided men, which is so common at the present time. Every student of medicine should study diseases of the pharynx,



larynx, and trachea as carefully as he does those of the lungs, liver and kidneys, and should be taught to use the laryngoscope as skilfully as he does the stethoscope.

Dr. Morell MacKenzie is an able physician, and probably the greatest living authority on diseases of the throat, and we would like to see his work occupying a place in the library of every medical practitioner in the country. He describes carefully the various kinds of instruments required, and his descriptions are always accompanied with excellent plates. He treats fully the different forms of pharyngitis and the diseases of the pharynx, such as cancer, tumours, syphilis, phthisis, neuroses, and disorders of traumatic origin. His chapter on Diphtheria and True Croup, which he considers identical, is especially comprehensive and instructive. The chapter on Diseases of the Tonsils also deserves special mention. He describes and treats in the same thorough and scientific manner all varieties of diseases found in the larynx and trachea, whether of local, constitutional, or traumatic origin.

In the Appendix he gives a number of special formulæ for topical remedies, such as steam and spray inhalations, gargles, lozenges, pigments, and insufflations; and specially indicates those which he has found most beneficial in his own very extensive practice. We regret exceedingly that our limited space prevents us from a more extended notice of many of the subjects he discusses so ably, and we only hope that our readers will supply the deficiency by a careful perusal of the work.

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*Biological Atlas.* A Guide to the Practical Study of Plants and Animals. Adapted to the Requirements of London University, Science and Art Department, and for use in Schools and Colleges, with accompanying text. By D. M'ALPINE, F.C.S., Lecturer on Biology and Botany, Edinburgh, and A. N. M'ALPINE, B.Sc., Lecturer on Botany, School of Medicine, Edinburgh, &c. W. & A. K. Johnston, Edinburgh and London, 1880.

We are in possession of a copy of the aforesaid Biological Atlas by the Messrs. M'Alpine, of Edinburgh, and feel called upon to say a word or two in its praise. It rarely happens that one engaged in giving instruction in a

special subject meets with a book so well adapted to the wants of his class. The truthfulness, accuracy and neatness which mark each of its pages, compel us to speak in very high terms of this book. In fact, after carefully scanning its contents, the only regret felt is that the authors should have stayed their hands so soon in such a good work. Had they extended their labours so as to include the Insecta, Reptilia Proper, Aves and Mammalia, we feel assured the Atlas would have been still more useful and instructive. However, with its present compass, perhaps, while inexpensive, it contains all that is absolutely required by the average college student with but little time at his disposal. It is a volume of fifty pages, and has twenty-four plates, comprising 423 coloured figures and diagrams. Eight of the plates are devoted to the vegetable kingdom; the remaining sixteen illustrate the comparative anatomy and histology of the animal kingdom. The cryptogamic plants taken up are Yeast, Bacteria, Mould, Chara, Protococcus, and the Bracken Fern. Plates VI., VII. and VIII. exhibit parts of flowering plants, and, we think, might be somewhat improved; for example, microscopic views might be substituted for those of the leaf of the Pea, the Horse-Chestnut and the Honeysuckle, which leaves themselves may be readily obtained by all students.

The Proteus and Bell Animalcules, Fresh-water Polype, Earth-Worm, Lobster, Crayfish, Mussel, Snail and Frog, are the animal types, the last seven plates being monopolized by the Frog, an amphibious creature that has frequently contributed to the advancement of science, and whose structure, physiology and development form a most interesting and profitable study. In order to give our readers some idea of the character and value of this Atlas, we here enumerate a few of the objects therein beautifully figured. In Plate XVII. portions of the edible Snail are represented, among which are the horny upper jaw, the radula, longitudinal vertical section of anterior portion of odontophore, subradular membrane with its longitudinal muscles, auricle and ventricle of heart with cephalic and abdominal arteries, the colourless, nucleated and amœbiform blood-corpuscles, blood-vessels in the lin-

ing of the pallial chamber, duct of salivary gland, the eye with its cornea, conjunctiva, sclerotic and choroid coats, retina and lens, the optic nerve, buccal nerve-ganglia, cerebral, pedal and parieto-splanchnic ganglia with branches, albumen gland, ovotestis and its duct, end of follicle of ovotestis, oviduct, vas deferens, duct of spermatheca, dart and dartsac, auditory canal and sac with otoliths in fluid. Plate XIX. shows the frog's skeleton with all necessary minuteness, different colours being employed to distinguish cartilage from true bone, as well as those bones that originate in cartilage from those that have their origin in membrane. Again, in Plates XX. and XXI. we find the ventricle and auricles of the heart of the frog, the bulbus arteriosus, right and left aortic arches, the cœliac, mesenteric, gastric, hepatic, dorsal, iliac, femoral, sciatic, splenic, carotid, and lingual arterial branches, the chief cranial nerves, a transverse section of the spinal cord and neural canal, the nervous supply to the muscles of the eye, and the vertical and horizontal longitudinal sections of the brain. Finally, in Plate XXIV. we have, what is of great interest and importance, a comparison of the histology of *Rana* and *Homo*.

### Meetings of Medical Societies.

#### TORONTO MEDICAL SOCIETY.

This Society met on the 18th Nov., 1880, the President (Dr. Covernton) in the chair. After preliminaries, Dr. Geo. Wright related two cases of syphilis; in one, in which the primary sore appeared on the lip, the source of infection was traced to a pipe which had been smoked by a person having mucous patches in the mouth. The second case was one of syphilitic psoriasis, in which the only source of infection appeared to arise from sleeping in the same bed and using the same towels as a friend with syphilis.—Dr. Graham had met with four cases of a similar character—the first in a male, with labial chancre, from the use of a syphilized pipe; the second and third both in girls, resulting from inoculation; and the fourth with a superciliary chancre without history.—Dr. Reeve mentioned a case of conjunctival chancre in an infant a few months old.

Dr. McPhedran related a case of luxation of lower end of the fibula forwards (published in another column).—Dr. Reeve then proceeded to read his paper upon some diseases of the Nasopharynx, Tympanum and Mastoid (will be published). The discussion was adjourned till next meeting. After some general business the Society adjourned.

At the meeting of Dec. 2nd, the President in the chair, Drs. T. S. Covernton, Rolph Lesslie and J. Lesslie were proposed as members.

Dr. Davidson exhibited a patient with a skin affection pustular in character, and confined exclusively to the back, and said to be of two years' duration. It resembles acne vulgaris.

Dr. Graham stated that a case of elephantiasis arabum under his care was improving under the administration of chaulmoogra oil internally and externally.

The adjourned discussion on Dr. Reeve's paper then came up; and after some remarks by Drs. Ryerson and Palmer, and a few questions from Drs. Nevitt and Cameron, Dr. Reeve closed the debate with a most able reply.

Dr. Graham then presented some pathological specimens from a case of lymphatic leucocythæmia under his care for four weeks. The disease ran a typical but rapid course. The lymphatic glands were universally enlarged. The spleen was not enlarged, weighing 5½ ounces. A small *lien succenturiatus* also existed. All the organs were unusually firm, and presented well-marked lymphatic infiltration. The lower lobe of left lung was perfectly white and almost absolutely solid.

Dr. Machell presented a patient, the subject of fracture of lower angle of scapula (published last month).

Dr. Geo. Wright related a case of chancroid in a boy of 13, said to have been caught from a girl of 11 or 12. He also related a case of cardiac syncope, in which a most alarming condition was brought on by slight exertion. There was no organic valvular disease and no pericardial effusion. The patient was improving under rest, ammonia and digitalis.

Dr. Workman read a translation of Gélinau's case of narcolepsy, and offered some remarks upon it. Any excitement caused the



man to fall into a sleep in which the pupils were dilated.—Dr. Cameron regarded the case as epileptic.

The following resolution was adopted: "That, in the opinion of this Society, the formation of an Ontario Medical Association is highly desirable, and that this Society will render what aid it can in such formation."

The meeting then adjourned.

#### ELGIN MEDICAL ASSOCIATION.

A regular meeting of the Elgin Medical Association was held at St. Thomas on Nov. 24th. Present: Drs. Going, Williams, D. McLarty, McLay, Vanbuskirk, Sinclair, C. McLarty, W. E. Smith, Tweedale, Cross, Kains, Fulton, and R. W. B. Smith.

The first order of business was the reading of the inaugural address of the President, Dr. F. B. Going, St. Thomas. The address, which was most suitable for the occasion referred to the objects of the Association, and exhorted the members of the Profession to take a lively interest in its welfare. One paragraph from the address was: "I think it is needless to enter much into the relations we owe to one another in our daily practice, as we have fully laid down in the code of ethics the course we should pursue, and which, if fully and conscientiously carried out, should enable us, at all times, to meet our brethren on the most friendly terms, and rise above the little jealousies that are so apt to separate us one from another, and which our friends outside the profession are but too glad to magnify and increase."

The address was highly appreciated by the Association, and a cordial vote of thanks tendered to the President for the same.

Dr. Vanbuskirk read an interesting and elaborate paper on "The Etiology and Pathology of Puerperal Fever." The discussion which followed was taken part in by all the members present; and the pleasant interchange of opinions which followed added largely to the interest of the meeting. The paper was well received, and Dr. Vanbuskirk received the thanks of the meeting for his contribution.

The Secretary read a communication from Dr. J. E. White, Toronto, regarding the formation of a Provincial Medical Association.

Dr. W. E. Smith moved, and Dr. Vanbuskirk seconde<sup>d</sup>, "That in the opinion of this Association it is desirable to recommend the formation of a Provincial Medical Association, in accordance with the objects stated in the communication of Dr. White."

Dr. D. McLarty was appointed to read a paper at the next meeting, which will be held at St. Thomas on Wednesday, January 11th, 1881, at 2 p.m.

R. W. BRUCE SMITH, *Secretary*.

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#### Miscellaneous.

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NITRO-GLYCERINE IN ACUTE AND CHRONIC BRIGHT'S DISEASE, AND IN THE VASCULAR TENSION OF THE AGED—THREATENED APOPLEXY, ETC. — Mr. A. W. Mayo Robson, F.R.C.S., of Leeds, writing to the *British Med. Journal*, details a number of cases of the above-named affections, in which striking benefit resulted from the employment of one minim to three minims doses of a one per cent. solution of nitro-glycerine. The most constantly observed effect of the diminished intra-vascular pressure was a copious secretion of urine.

TEMPERATURES OF THE SKIN OF THE THORAX. — M. Redart communicates the results of his researches on the temperatures of the skin of the thorax in the physiological state, and in pleurisy and pneumonia. It results from the researches of M. Redart that the temperature of the skin of the thorax is liable to considerable variations. A temperature of 10° or 12° C. (50°—53.6° F.) being applied to a portion of the skin of the thorax, the temperature is lowered from one degree to one degree and a half. This or some other portion being covered over with wadding, its temperature rises in a notable manner, and is comparable to that of the axilla. The average temperature of the skin of the thorax is in the normal state from 35.5° to 34.6° C. (95.9° to 94.28° F.). There are differences of three, four, or five-tenths of a degree between the two sides of the chest, according as the extremity of one of the upper limbs is placed in hot water or cold.

In pleurisy, if the healthy is compared with the diseased side, in a great number of cases no differences are found. In pneumonia there is generally a slight hyperthermy of the diseased side, but it is produced over the whole side, and not only at the level of the diseased portion. In no case is the temperature of the thorax superior to that of the axilla and rectum.

All these researches and experiments have been made by the means of, not thermometers, but thermo-electric apparatus.—*Gaz. des Hôp.*



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# THE Canadian Journal of Medical Science.

A MONTHLY JOURNAL OF MEDICAL SCIENCE, CRITICISM, AND NEWS.

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TORONTO, FEBRUARY, 1881.

## Original Communications.

### BRAIN LESIONS AND FUNCTIONAL RESULTS.

BY DANIEL CLARK, M.D., TORONTO.

(Read before the Canada Medical Association, at Ottawa, Sept. 1st, 1880.)

(Continued from page 4.)

It is satisfactory to see that recent investigators are paying more attention to the central organs. Their researches go to show that very important functions are likely to be found having their excito-motor centres in the internal parts of the brain. These experiments, as far as they go, point to the probabilities of my theory of localization. Richet, in speaking of cerebral excitation by means of electricity, is forced to say in explanation of certain phenomena, "Known facts demonstrate that excitation of the convolutions which surround the sigmoid gyrus act with extreme energy upon the ganglionic centres of the brain (opto-striated bodies). It is possible that such excitation culminated in the cerebral centres, and that these centres thus surcharged discharge to the muscles." Charcot says, in speaking of the lenticular nucleus of the *corpus striatum*: "These grey nuclei are possibly so many centres endowed with distinct properties and functions." This is a germ idea of the theory which I propounded several years ago in the following words: "Large portions of the cerebrum and cerebellum may be taken away from the living body without immediate danger of death; but the organs in the base of the brain, from which spring the numerous nerves so essential to life, cannot be touched in

vivisection or by disease with impunity. From this central region nerve influence radiates to every part of the body, making its connections with the depositories of nerve-power in the spinal cord and with the ganglia of the sympathetic system."—(*Vide* "An Animated Molecule," p. 38.) If Charcot had added to his hypothesis the probability that the base and central ganglia were the true and only motor centres, a solution of the difficulties which surround the Ferrier system could be arrived at without ignoring the doctrines of localization. Let the area be circumscribed to really the most vital parts of the brain, then, could all phenomena be explained. It would then become more evident why traumatic injury and destruction from pathological processes are not always followed by functional and mental unsoundness. If this explanation be accepted, it will be seen that the surfaces and upper portions of these nervous masses thus become adjuncts to vital organs in the centre and base of the brain. The former, in their analogy of structures and juxtaposition, give power but do not impart function; they are auxiliaries, but not necessities, to the ganglionic centres; they intensify energy, but do not direct; they are, as it were, additional cells to the battery, but are not its controlling agency. I repeat this view in another form to avoid ambiguity and misconception.

It is worthy of remark in this connection, as it is a matter of experiment, that such a large area as the Rolandic zone can be destroyed, and yet leave the intelligence unimpaired. A considerable portion of the frontal or even of the occipital lobes can be removed without any apparent alteration of the intellectual powers.

The corresponding lobes of either the frontal, occipital or parietal regions have been destroyed without affecting the conscious being, or those functions said to have their seat of power in these parts. It is evident then that these are not the *sole* habitations of mind or certain physical operations. The reciprocity between mind and body is strikingly seen in aphasia. There can be no aphasia without more or less impairment of the memory, judgment and imagination. Yet this functional and mental disorder can exist either with or without injury to the third frontal convolution. What basis then is there to suppose it so necessary to certain physical operations?

If it could be shown that sight, hearing, tasting, often were accomplished when the optic, auditory, and gustatory nerves and the region of their insertion, were destroyed, then would it be plain that these were not the only tracts of nerve influence for these centres of special sense to reside in, nor the avenues of each peculiar manifestation of sensation. In the same way, if we can have aphasia, paralysis of the legs, arms and face, with these so-called centres of nerve force unimpaired, or if impaired without these results, then is it beyond controversy that this doctrine of the cortical localization of specific functional energy is not proven. What may be in store in the future for these earnest and honest workers is only a matter of conjecture. As Richet pertinently says (page 115), "If the convolution which surrounds the crucial furrow is really the motor centre of the legs, then by removing both right and left convolutions the legs should become paralyzed; if not, then is it not a true motor centre. It would then be necessary to admit that there are several organs for one function, several motor centres for one limb, which is contrary to probability and to fact." He suggests as a way out of the difficulty that as the spinal cord conduction (according to Vulpian) is carried on equally by all parts of the grey matter, it is possible that the same indifference holds for the brain, though less in degree. In other words, *there are habitual roads, but no compulsory ones*. This view would be, if true, a death blow to the organic local

theory as applied to the cortex. This theory would not meet Ferrier's definition of localization, which is said by him to be "a complex arrangement of individually differentiated centres, which in associated action regulate the various muscular adjustments necessary to maintain equilibrium of the body."

It will be seen that so far the greatest interest centres round the third left frontal convolution, on account of the stress laid on the fact that aphasia is so often found as a result of its injured or diseased condition. If it can be proved that this imperfection of speech is always conjoined with an impaired condition of this locality, and *never otherwise*, then is the battle won for localization of functional power in the cortical substance, for it would be fair to infer that other centres for other functions would be found in similar parts of the same field of investigation. Unfortunately for this doctrine, the exceptions to these results are too many to be ignored, and these show that this spot is not the centre of speech, nor its injury the sole cause of aphasia. It has been found in numbers of examples that aphasia is found with this convolution intact. Not only this, but it is known that speech, in its different forms of language, such as writing, reading, singing, drawing, and imitation—in fact, aphasia in all its forms—follows lesion in the Island of Reil. (*London Lancet*, Amer. Ed., July 1880, p. 34.)

Aphasia is known to exist as the result of disease in the right hemisphere, and that not in the corresponding third frontal of that hemisphere. It cannot be supposed this reputed motive brain tissue which excites the functions of speech may be destroyed, and yet the peculiar energy which animates it can remain unabated after its obliteration has taken place, unless it is claimed that the corresponding convolution on the right, in a vicarious way, does the work of its fellow. If such were the case, then the third left frontal convolution could claim no pre-eminence as the sole seat of the faculty of articulate language. To get over this difficulty, this school of thinkers introduces what is called *the theory of supplementation*. They say some other part of the cortical substance comes to the rescue when



any centre of function is destroyed. This neighbourly assumption of peculiar and distinct labour is not found in any other part of the system, however willing the organs may be to give a helping hand to one another. We are told it may be the corresponding part of some other cortical area. This is virtually a giving up of the doctrine of these so-called "true motor centres."

Here let me say, in passing, that a fallacy in vivisection often arises in forgetting that experiments on the brains of inferior beings by the destruction of parts do not always produce analogous effects on man when corresponding parts are injured. We may remove the whole of a cerebral hemisphere of a pigeon or rabbit with the only functional result of a slight impairment in flying or jumping. No hemiplegia will follow, such as is the case with like injury to the dog or monkey. Man is much more sensitive to such lesions, only in certain parts. In fact, the whole brain may be removed in many creatures without affecting their locomotion. We know that in man disease, such as sclerosis, and softening, may cut off the spinal cord from cerebral influence, yet functional activity goes on with unabated vigour. In the same way, we find that if the base and central organs remain unimpaired, no marked symptoms arise, except by sympathetic connections with adjacent parts. This shows the fallacy of reasoning by analogy between man and animals based on experiments. There are common results and also great differences.

It is now important to say a few words about the circulation of the blood in the brain, to show how much more plentifully the centre and base are supplied with blood than are the superior parts of the cerebrum and cerebellum. *It is not to be forgotten that where the largest supply of blood is needed, there is found the greatest functional activity.* We are all well acquainted with the wonderful distribution and anastomoses of the blood in the base of the brain, both in the circle of Willis and in the cerebral arteries springing from this polygon of vessels. We are also aware of the fact that two sets of branches shoot from these main trunks in almost parallel lines. The one

class goes into the medullary and cortical substance in an outward direction from those central reservoirs, but does not reach the surface. Another class runs to the periphery and forms the *pia mater*, from which branch inwards numerous arterioles to supply the cortical and medullary parts not reached by the vessels springing from the centre. These two sources of supply are not only distinct as between each of their own vessels, but also unconnected to a great extent with one another. The anastomoses between these two sets of vessels is very slight indeed. The streamlet in each can be dried up or seriously interrupted in many ways without disturbing the neighbouring vessels to any appreciable degree. This accounts for so many circumscribed lesions in these parts, and for the little effect they produce on the adjacent tissues and circulation. I am inclined to think, that on account of this localization of circulation, and consequently a tendency to restricted areas of disease, a good many fallacies of reasoning have obtained currency in respect to centres of function. Heubner cites pathological cases which indicate that obliteration of one of the large vessels of the cortical system, or any of its branches, has during life given no pronounced symptom. (Charcot.)

Let us now turn to the arterial circulation in the *grey central ganglia*. This section includes the *thalami optici*, the *corpora striata* and their appendages. It needs only a moment's reflection of our anatomy to realize that the central ganglia are largely supplied from the Sylvian artery, as well as from the nutrient vessels, which spring in large numbers from all the cerebral arteries and from the basilar at its bifurcation. The sum total of all these shows a much greater capacity for blood supply per square inch than in any other part of the brain. Such being the case, we know this augmented normal supply means proportionally increased activity. Hence it follows as a matter of fact that any abnormal increase or decrease of blood means a greater or less physical or mental perturbation. Congestion, as well as anæmia, is followed by the same results—that is, more or less suspended sensibility and retarded voluntary action. Where the blood supply is found to be



naturally the most copious, there is greater susceptibility of this kind, and as a corollary it may be added, there is functional activity in proportion to the normal blood supply. The difference in this respect between the cortical substance and the central parts is most marked. This points to the former as being only subsidiary to the latter, taking the circulation as a physiological basis to judge from in this respect. Although the central and base ganglia are much less in bulk than is the cortical substance, yet, about one-half of the blood which enters the encephalon is distributed to the former. It would be interesting to know if this unequal supply has anything to do with the pathological fact that in hemiplegia from cortical disease we find it "limited, transient, and variable" (Charcot), but in paralysis of the body from central disease it is permanent, general and uniform. It is a pathological fact that paralysis, general or partial, can be produced by *any part* of the brain being affected with inflammation, embolus, or tumour; showing that loss of function is not consequent on degeneration or destruction of some localized spot. That part of the brain which demands the greatest amount of blood in the performance of its work must necessarily have the greatest activity.

Let me then repeat in another form that a very superficial knowledge of the brain circulation indicates how direct and ample is the blood supply to the base and central ganglia in comparison with the cortical supply. This is especially true of the arteries which run to the *corpus striatum* and *thalamus opticus*. The cortical substance is nourished in a roundabout way through the *pia mater*, but the central system is reached directly through the large central vessels springing from the circle of Willis, which furnish a perfect fountain of blood supply near at hand. So distinct and important is the circulation in this grand centre, that when obliteration of the Sylvian artery takes place, all the ganglionic centres are affected, and cerebral hemiplegia accompanied by hemianæsthesia is the result. This physiological fact alone shows the greater importance these ganglia hold—it seems to me—as functional centres in comparison to the cortex or even the

entire hemispheres. Since writing the above, I find that Prof. M. Schiff, of Florence, has caught the same idea, when he says, in his monograph on "motor centres," that "human and comparative pathology have stated with certainty that the motor centres do not extend above the base of the brain." Unless my attempt to be brief has led to ambiguity, it will be seen that among the probabilities of this obscure subject, the explanations I have given in defence of the theory enunciated are based on—

I. The radical difference found in the circulation of the blood, both as to mode of distribution and quantity, leading to the reasonable inference of greater functional activity existing in the centre than in the circumference of the brain. The more life-action in any part, the more is blood supply needed.

II. The want of uniformity in functional results, when definite and alike portions of the cortical substance are stimulated, impaired or destroyed; hence, this cannot be the seat of so-called true motor centres.

III. It would be consonant with pathological and experimental facts to locate these motor and physical centres in the base and centre ganglia; yet in sympathetic relations, being influenced, but not absolutely controlled, by the cortical substance.

IV. The want of distinctive physiological features in the different convolutions.

I will now give a few examples of brain injury, illustrative of these views. The first are culled from the surgical records of the war of the late American rebellion:

Private Hughes was wounded at the battle of Antietam. The hospital reports say that the injury was a perforation of the skull by a single conoidal musket ball entering near the inner posterior angle of the right parietal, and emerging at a higher point of the left parietal, making, after traversing a portion of the brain, a large exit wound. At the time of this extensive injury he dragged himself from the field, but *he did not lose his consciousness*. Eight days after the injury, it is reported the general condition of the patient was good; suppuration had commenced, no febrile action existed, the pulse was regular; sleep not ma-

terially disturbed, *mind clear*, and manifested no signs of compression of the brain, or inflammation of its membranes. When the swelling of the scalp subsided, a prominence of brain substance was found—one inch in height, and three inches in length—in which the pulsation of the arteries could be distinctly observed. Spiculæ of bone came away from time to time, and the tumour subsided within the cranium. On December 20th, 1870, or over eight years after the injury, he was examined by two medical men. Previous to this time he had worked in an iron foundry. His memory remained quite good. He had no paralysis, and it is reported by Drs. Keen and Thomson that it is remarkable to observe the almost entire restoration of his mental faculties, especially in view of the probable deep lesion of the brain, both by the primary injury and the subsequent fungus cerebri.

It will be seen that in this case there was no functional disorder, except that, for a short time at first, "the brain functions seemed clouded." This might be expected for a time.

Private Sheridan was shot through the left temporal region. The missile lodged in the brain and was never extracted. At the close of the war he was discharged—recovered, and received no pension. No functional disturbance.

Corporal Farnum, wounded by a round ball entering the cranium and brain matter. He recovered, and was put on the Veteran Reserve Corps. He was not pensioned. He was none the worse for the wound.

Private Dillon was wounded by a bullet which entered the cranium very near the superior angle of the occipital bone, and had passed anteriorly into the substance of the brain. He lay on the field of battle two days without any attention. After being a year invalided he returned to active service, perfectly well physically, but with the intellect slightly impaired. Afterwards he was mustered out of the service perfectly well, and was not pensioned. The ball was not extracted. After the first shock there was no functional disturbance.

Private Bemis, wounded by a ball entering a little outside the left frontal pro-

tuberance, and passing backwards and outwards. It removed a piece of the squamous portion of the temporal bone, with brain substance and membranes. When the patient entered the hospital, brain matter was oozing from the wound. At first, respiration was slow; pulse 40; the right side was paralyzed, and there was total insensibility. Three days after the injury the bullet was extracted from the substance of the left hemisphere. It was a conoidal ball and badly shattered. He then rapidly recovered, and the report says that in four months and a half afterwards "the mental and the sensory faculties were unimpaired." On October 30th, 1870, he wrote: "I am still in the land of the living. My health is good, considering what I passed through. My head aches some of the time. I am married and have one child. My memory is affected, and I cannot hear as well as I could before I was wounded." These were the only results of this extensive laceration of brain matter. The slight functional disturbance did not correspond with the doctrine of cortical functional centres.

Sergeant Rotherham, wounded at Gettysburg by a musket ball, which penetrated the skull near the right frontal eminence, passed directly inwards and lodged somewhere on the membranes or in the brain substance. The opening through the bone was similar to that made by a trephine, and the track of the ball could be followed on the *dura mater* with a probe for a considerable distance, as that membrane was detached from its natural connection with the skull. The ball was not extracted. There was no perceptible loss of power, motion, or sensation on either side of the body. There was no arterial excitement. His recovery was rapid, and five weeks after the injury he was furloughed for fifteen days, at the expiration of which time he returned to duty, having suffered no inconvenience from the injury. After this several bones exfoliated, but his mind was not impaired to any perceptible degree. For some time after the wound was received, he was assigned light duty in the Veteran Reserve Corps Hospital.

Lieut. Brown, at the battle of Wilson Creek, received a penetrating gunshot wound of the



cranium and brain. The ball was not removed for seven years after the injury, but in a few days after being wounded he was fit for duty. In January, 1871, this officer was on duty as captain in the 13th Infantry.

Private Stallman, wounded at Winchester by a musket ball, which entered at the right temple and emerged at the opposite side of the head. In spite of this serious lesion of brain, in a few months he was put on light duty. He had no strabismus, and we are told that, although his mental faculties were slow and uncertain and his memory impaired, he had no hallucinations nor mental aberrations. The year following the injury he was pensioned. No functional impairment except the above mentioned.

Private Haggart was wounded by a conoidal musket ball, which struck the left side of the head, and passing through carried away a large part of the left half of the occipital bone. At first he became insensible and lost more than an ounce of cerebrum, leaving bare the meningeal artery. Seven months afterwards he was discharged from the hospital. At that time both eyes were dilated, causing dimness of vision, but his intellect was good, and he could read very coarse print. He died four years afterwards, but it is not recorded what was the cause of death. This extensive lesion only produced these slight results.

Sergeant Woodman was wounded by a gunshot missile, which entered above the left frontal eminence and emerged at a point one inch behind the upper margin of the right ear. He was unconscious for several hours. At the wound of exit eight small bones afterwards discharged. He was alive three years afterwards, and it was reported that the organs of special sense and the intellect were unimpaired.

Private Plumly was wounded by a conoidal musket ball, which entered at the inner angle of the left eye, and after passing through the brain substance it emerged behind the left ear. On March 7th, 1867, nearly three years after the wound was inflicted, he was in good health, and a pensioner. The only physical results were obscuration of the vision of the left eye for a short time, the discharge of pus from the orifice of entrance of the ball and through the right nostril and upper part of the posterior nasal cavity into the mouth.

Private Sechler was wounded by a conoidal ball, which struck the *os frontis* over the right eye and passed into the brain. He not only lived, but returned to duty six months afterwards, and was at the close of the war mustered out so well that he did not even receive a pension. The ball was not extracted. No functional results.

(To be continued.)

## PLASTIC OPERATIONS ON THE EYELIDS.

BY R. A. REEVE, B.A., M.D.

Lecturer on Ophthalmology and Otology, Toronto School of Medicine, and Surgeon to Andrew Mercer Eye and Ear Infirmary.

(Read at Meeting of Canada Medical Association, Ottawa, Sept. 2, 1880.)

(Continued from page 6.)

### CASE 2.—*Ectropion of Upper Lid, treated by Transplantation of Flap without Pedicle.*

Though second in order, this was the first case in which the above method was followed; and it was the fourth, so far as I was then aware, on this side of the Atlantic, the first being reported by Wadsworth, of Boston, and the second and third by Aub, of Cincinnati. The patient had psoriasis (non-specific) to such an extent that one could hardly get a patch of healthy skin large enough for a flap; and I did not wish to operate until he had fully recovered, as there was little likelihood of success; but it was (now or never) with him. When admitted, the left cornea was sloughing, owing, seemingly, to exposure of the globe from ectropion—the result of an injury received some months previously. The lower lid was drawn downwards and outwards, and everted, and all the skin of the upper lid was destroyed, except at the ciliary edge, which was adherent to the upper margin of the orbit, where slight exfoliation of bone was going on. All the surrounding tissue was cicatricial, and a flap with pedicle could not be had.

As it was too late to attempt to save the cornea, palliative treatment was used until the inflammatory action had ceased and the carious spot had healed; and on the 25th of June, 1879, the operation was done. The lower lid was first brought up into place by incisions making a triangular flap with base to free border (upwards), some burrowing and subcutaneous division of bands of adhesion, and then the sliding upwards and inwards of another flap (rectangular), with its base under the malar process.

The upper lid was freed by an incision a little above the eyelashes, and some dissection. The free edges were then made raw at four corresponding points, which were brought



together by sutures. A large piece of skin was then cut away from the arm, made as thin as possible, trimmed, fitted, and adjusted upon the upper lid, and all the parts covered with gold-beater's skin, compress and bandage.

Not to go into too many details, the transplanted skin did not unite save at one point, and had to be removed after a few days; and grafting, by means of small grafts, was afterwards done. The patient was discharged on the 22nd July, 1879, cicatrization being complete.

The lids had parted slightly, short bands having formed by traction at the points of union, the division of which was deferred.

*Remarks.*—It need hardly be urged that this method of blepharoplasty conveys a lesson of practical moment in general surgery. In some cases, at least, the planting of a large piece of skin on a raw (lymph-exuding) surface will be found preferable to the old plan of putting small grafts on a pus-secreting one. Much painstaking care is required in its execution, and the tendency of the flap to contract is certainly a disadvantage; but it is sometimes available when other methods are not, and its results seem to compare favourably with those of transplantation of large flaps with pedicle.

Dr. H. D. Noyes, of New York (N. Y. *Medical Record*, March 27th, 1880), after reporting some successful and unsuccessful cases of his own, and citing others, says,—“A number of cases have proved failures. In some of these instances failure is sufficiently accounted for \* \* \*; at the same time, if out of fifteen cases ten have proved successes, it is something remarkable.”

In my own cases there were two successes and one failure, the latter being almost a foregone conclusion.

A few points should be observed, which, if not essential, are most important. 1. In contrast with other flaps, the transplanted skin should be thoroughly freed from subcutaneous connective tissue and fat, which is most easily done by means of sharp scissors. 2. It must be adjusted and the edges coapted with the greatest nicety, all oozing of blood having ceased from the raw surface, which should be quite clean; and it should be kept well covered

and undisturbed. 3. Allowance must be made for extraordinary contraction of the skin after its removal, say 35 to 50 per cent., and for further shrinkage after union. 4. The general integument and the subject should be healthy. 5. The special indication in blepharoplasty is the destruction of the skin of the lid or lids, with preservation of their free edges, so that they can be temporarily united; the tissues around the orbit being so altered or diseased as to preclude or jeopardize the proper nourishment of a flap through its pedicle. And it is to be preferred, *cæteris paribus*, when there is a likelihood of increasing the deformity by utilizing the skin of the face after the usual methods.

#### CASE 3.—*Epithelioma of Eyelids and Inner Canthus. Blepharoplasty by Sliding Flaps.*

Mr. M—— consulted me July 27th, '77, in regard to disease of the lower lid of the left eye, which had begun in 1862 as a large pimple on the edge of the lid near the lachrymal punctum, with ensuing excoriation, slight discharge, and scabbing. For the first twelve years the disease was confined to the inner fourth of the lower lid. It then began to creep outwards. There has been no pain from the outset. The whole ciliary border of the lid is now involved, the inner fourth presenting an ulcerated fissure, with hard, slightly-raised edges, and there is partial ectropion. The immediate removal of the diseased tissues was advised, but the case was not seen again until July, '79, when the outer canthus and also the lachrymal sac and the inner end of the upper lid had been invaded. An operation was again advised, a guarded prognosis being given.

July 21st, '79, the patient being anesthetized by Dr. Zimmerman, and Dr. Covernton, the family physician, kindly assisting, the whole of the lower lid from the ocular conjunctiva to below the edge of the orbit, the outer end of upper lid as well as its inner fourth, and the lachrymal sac with some of the orbital tissue behind it were cut away. An incision was then made down the side of the nose, and a large horizontal flap dissected back with its base on and below the malar bone. This was slid up against the globe, and its upper

edge stitched to the upper lid (to form the outer canthus) and to the ocular conjunctiva, and at its inner free end to the apposed part on the side of the nose. To restore the inner canthus and upper lid another horizontal flap was made across the root of the nose, and its free end then drawn over and carefully united to the raw vertical edge of upper lid by a twisted suture and stitches. Strips of plaster, cotton wool and bandage were then applied. Both flaps united satisfactorily. Grafting was done on the raw surface below the lower flap to lessen cicatricial contraction, and some suspicious looking tissue near the site of the sac afterwards destroyed by chromic acid.

Five weeks after the operation (Aug. 28), the new part of upper lid was well back in position, and the patient could just uncover the pupil so as to see straight forwards, and could read with facility. The eye was comfortable, though there was some epiphora. A microscopic examination by Dr. Zimmerman confirmed the diagnosis of epithelioma.

On several occasions during the year a small growth appeared about the inner canthus, yielding at once to treatment.

P.S.—Jan., '81. There has been no sign of relapse, apparently, during the last six months.

#### CASE 4.—*Epithelioma of Eyelids. Plastic Operation.*

T. C. D., æt. 51, was admitted into the Andrew Mercer Eye and Ear Infirmary, Dec. 19, '79. The patient ascribes his affection to a burn caused by molten lead splashing into his eye five years ago. The sore would not heal, he says, but remained as a red lump with a white top near the caruncle for one year, when it spread to the lower lid. Treatment by caustics was tried ineffectually. Eighteen months ago, epithelioma was diagnosed after a microscopic examination. One year ago the side of the nose was invaded, the ulceration creeping very slowly and painlessly.

*Present condition.*—The inner fourth of the upper lid, nearly to the brow, is eroded and perforated and surrounded by a hard, raised border; and there is also erosion of the inner canthus, lachrymal sac, and inner two-thirds

of the lower lid. The globe itself is intact, though the conjunctiva bulbi at the inner and lower side has a doubtful look.

On Dec. 27th the following parts were cut away: the inner three-fourths of the lower lid and inner two-fifths of the upper, all the lachrymal sac and some orbital tissue behind it, part of the ocular conjunctiva, as well as a square piece from the side of the nose down to the periosteum. A large flap was then made reaching from the side of the nose to the malar process,  $3\frac{1}{2}$  inches long by  $1\frac{1}{2}$  inches wide, and was slid up against the eyeball, its upper edge being stitched to the conjunctiva bulbi, and its free end in position at the root of the nose. To repair the upper lid a flap was taken from the top of the nose and the forehead, and then turned horizontally, the original lower edge being fastened to the vertical raw edge of the upper lid by a pin and three sutures after the fibres of the orbicularis muscle had been divided at the outer canthus to allow the lid to give towards the nose. The adjacent edges of the two flaps at the root of the nose were also stitched together, and the upper edge of the upper flap and the skin under the brow. A pad was put on the lower flap to keep it in contact with its bed, and supporting straps, cotton wool and bandage applied. On the third day all the dressings were removed. The flaps looked well; vaseline compress and straps re-applied. On the fourth day no pain or inflammatory reaction present; no discharge from orbit; took out pin and some threads. On the fifth day removed the rest of the stitches, putting collodion across the upper lid before all were cut out. Subsequently, put twelve grafts on the raw surface below, but with indifferent effect; also had to destroy sprouting granulations at the site of the sac. The patient was discharged January 28th, '80, the parts having healed.

On July 27th he was re-admitted, and the rest of the lower lid cut away, mainly to relieve his own anxiety. A canthotomy was also done, and division of external palpebral ligament to render upper lid lax and remove discomfort from friction.

August 20th, patient discharged. The inner canthus has cicatrized back to the plane of the right. There is some annoyance from lachrymation, for which extirpation of the lachrymal gland may hereafter be done.

P.S.—Jan., '81. Patient reports no relapse to date.



NOTES OF A CLINICAL LECTURE AT  
TORONTO GENERAL HOSPITAL,  
SESSION 1880-81.

CLINIC OF DR. THORBURN.

CASE I.—*Third Stage of Bright's Kidney—Hypertrophy of Heart.*

CASE II.—*Mitral Regurgitation.*

CASE I.—*History.*—J. C., æt. 32, was admitted to the Hospital, and examined November 24th, '80. Native of Canada; has lived for last 22 years in Toronto; is brakesman G. T. R. Married two years ago; wife and child living. His previous history is moderately good; was always a strong, healthy man; good constitution, but has been in the habit of drinking heavily. Has always noticed a remarkably abundant excretion of urine, pale; but when troubled with a cold, felt pain across region of kidneys, and the urine then was high-coloured. Six years ago had severe attack of inflammatory rheumatism, which seemed to settle in right leg and left arm; he was obliged to use crutches for a while, but this attack left no permanent noticeable bad effects.

Has had two attacks of gonorrhœa—the first ten, the second seven years ago. Was slightly injured in the head about one year ago. No hereditary predisposition to disease, as far as can be ascertained.

*Present disease.*—About seven weeks ago felt a severe pain over the region of the heart, which continued for three weeks. His face was œdematous at night when in bed, but resumed its normal condition during the day; bowels costive; urine decreased in amount. He knows of no cause for this attack.

After three weeks of treatment went to work again, but felt poorly; worked for ten days, and one morning, after a heavy lift, found himself unable to go to work, the symptoms above given having returned in full force. Again he received treatment; but not improving, was sent to the hospital.

*Present condition.*—In walking, seems very weak and unsteady; in bed, he lies by preference on his back, shoulders and head elevated. If he lie for any considerable time on his side or with head low, dyspnœa supervenes. Coun-

tenance anæmic. Pulse 108, not very compressible; in fact, rather incompressible. Respirations 36, short and shallow. Extremities cold and anæmic; the lower decidedly anæsthetic. Tongue shows a coating of whitish fur. He has been troubled considerably by epistaxis for last four or five days. No appetite; can keep nothing on stomach but a little dry toast, milk or eggs; vomited his medicine while under treatment, before coming to hospital; very thirsty, but refrained from much fluid. No pain except a little in arms and shoulders. Shows general anasarca. Liver very tender; right lobe enlarged. Heart shows considerable hypertrophy on percussion; reduplication of the sounds heard best over base. Action of the organ impaired. Urine pale in colour, decreased in amount; specific gravity 1006; acid in reaction; contains large quantity of albumen; no sugar. Microscopical examination shows the presence of granular casts, mucous cells, and degenerated epithelium of both renal and cystic varieties.

The following is the substance of Dr. Thorburn's remarks in reference to the diagnosis, prognosis, and treatment of the case:—

In forming our diagnosis we must take into account two factors, prominently brought out in the history just read: namely, the evident abnormal condition, first, of the heart, then of the kidneys. Some gentlemen might be disposed to ask, Why not include the anasarcaous condition as a factor for consideration? To this it may justly be answered, because the history of the case shows this plainly to be not a primary condition; not a cause, but an effect. And this effect may have been produced, is frequently produced, by abnormal conditions either of the heart or kidneys. Our present object, then, is to ascertain whether the enlargement of the heart produced the diseased kidneys, or *vice versa*, and thus to discover the cause of the condition of the system now before us.

Considering, first, the heart, we find a history of a rheumatic attack of some severity. Knowing the tendency of such attacks to involve this organ, its condition must be carefully noted. We find it to be abnormal in two respects; first, organically, it being increased

in size ; in the second place, functionally, the sounds being altered.

But rheumatic attacks chiefly tend to produce valvular affections. Now, there is no evidence, after the most careful auscultation, of disease of the valves here. Neither the hypertrophy, then, nor the reduplication of the sounds can be held to point to heart disease brought on by the rheumatic attack as the prime cause of disease in this case ; in fact, these conditions both help to sustain the idea that the real origin of the trouble is to be sought for in the kidneys.

What evidence can be adduced from the history or present condition of this patient to uphold this opinion ?

In the first place we must remember that he is stated to have been a heavy drinker. This habit is well known to tend towards a cirrhotic condition of the kidneys, as well as other organs—a condition characterized by hyperplasia of the connective tissue of the gland, and consequent increase in size, followed by atrophy and diminished bulk, which latter state is seen in the most advanced cases of chronic Bright's disease. Now, we must remember another fact indicated by his history. For a long time previous to the present attack the urine was excessive in amount ; and the kidneys were easily disordered by slight causes.

We have here sufficient data to pronounce the kidneys to have been more or less affected for a considerable period.

Might this of itself tend to produce the abnormal heart conditions previously noticed ?

To answer this question we must remember, not only that in chronic Bright's disease there is a tendency to hypertrophy of the heart muscle, but that also the lumen of the smaller arteries of the body is diminished, while their coats are thickened, and become more or less rigid. To this latter fact is due the comparatively high tension of the pulse in a case of chronic Bright's disease, and also the general enlargement of the organ ; caused, of course, by the extra amount of force required to send the blood through the narrower passages.

This is sufficient answer to the query, in so far as the size of the heart is concerned ; and it also explains why we have, in this case,

with a comparatively weak heart action, a better state of arterial tension than might have been expected.

In regard to the reduplication of the sounds this is said to be an occasional accompaniment of Bright's disease, but you will rarely have so good an instance as the one now before us.

The history then gives us good ground for diagnosing a case of chronic Bright's disease, and this is the primary cause of the present condition. And when we take into account the present condition of the urine of the patient, its abnormal constituents, with the other symptoms, no room for doubt is left.

The stage to which the cirrhosis of the kidneys has reached is a matter of some interest. It seems highly probable that there is a certain amount of fatty degeneration present, together with a more or less granular condition of the gland. But an autopsy alone would reveal their condition positively.

The prognosis is unfavourable, as in all such cases, where we know that there is a considerable amount of organic change. The treatment is merely palliative, consisting mainly of a heart tonic and suitable diuretic. Plenty of nourishing, easily digested food is ordered, and the state of the bowels well looked after. He receives :

R Tr. Digitalis..... ʒiij.  
Tr. Card. Co ..... ʒjv.  
Aquam ad..... ʒjv.  
Sig. ʒij. every six hours.

[Subsequent to the clinic, the following notes of the case were taken :

Dec. 3rd. A condition resembling eczema has appeared on the legs, epistaxis is frequent, feels pained over the region of the kidneys, orthopnea well marked. He drinks much water ; urine is more plentiful ; not so much albumen present. Bowels acting well. Pulse 110.

Dec. 10th. Urine much more plentiful ; acid ; albumen decreased ; eczema disappearing ; anasarca condition not so apparent ; appetite better ; pulse, 104 ; respirations, 28.

Dec. 16th. Pulse, 100 ; respirations, 28 ; the albumen in the urine largely increased. From this time he gradually sank, the quantity of urine decreasing.



About Dec. 27th, he became helpless; urine almost entirely suppressed; the small amount secreted was removed by catheter; eyes protruding; partly delirious.

Dec. 30th. Evident uræmic poisoning; comatose; died in that condition, Dec. 31st.

It was the intention to have held a *post mortem* examination, but the friends claiming the body, the diagnosis unfortunately could not be thus confirmed.]

CASE II.—Dr. Thorburn also drew the attention of the class to a case of heart disease, which formed a very instructive contrast to the case detailed above.

T. S.— had also been rheumatic, and showed general anasarca. This was due, however, to the condition of the heart, which, on auscultation showed well-marked indications of valvular disease. The mitral valves were chiefly involved, the murmur being regurgitant.

#### EXTENSIVE VENEREAL WARTS.

BY H. T. MACHELL, M.B., L.R.C.P. EDIN., TORONTO.

On the 1st of December last a patient presented herself, saying she had "the chancres." The history of the case, however, pointed to gonorrhœa, which she said she had contracted six months ago. On making an examination, the whole circumference of the vagina, from the labia minora backwards for an inch and a half, was completely studded with venereal warts, while above this these growths were scattered here and there up to within a few lines of the cervix uteri. These vegetations so packed the anterior portion of the vagina that when the labia were separated the direction of the canal could not be made out at all, and it was with considerable difficulty that the finger could be introduced.

They varied in size from a pin's head to that of a good-sized pea, but the greater number of them were flat and smooth, and frequently three or four could be seen attached to one pedicle.

Nitric acid was applied a few times at intervals of three days; then the remainder were clipped off with the scissors at a couple of sittings, and the acid applied to the base of the pedicles. Result good.

#### THE TREATMENT OF SPRAINED ANKLE.

BY R. L. MACDONNELL, B.A., M.D., M.R.C.S. ENG.,  
Assistant-Demonstrator of Anatomy, McGill University,  
Montreal.

According to most writers of text-books, the management of a sprained ankle is a simple affair indeed. An evaporating lotion, perhaps iced applications, a few days in the house, and the surgeon's duties are over. Some writers mention that starched bandages may be applied in very severe cases. Every one will acknowledge, I think, that a sprained ankle may turn out a very troublesome accident; that sometimes its effects last for months, that usually the unlucky patient must stay in bed or upon the sofa for at least a week, and that upon resuming his occupations the joint will be for a long time weak, and prone to turn under, when the weight of the body is unexpectedly thrown upon it. The object of this communication is an attempt to show that all these unpleasant consequences may be in a great measure obviated by the use of some fixed apparatus, whether of plaster of Paris or of any other similar material. The application of a splint of this kind relieves pain, reduces swelling, and enables the patient not only to walk about his house soon after the application of the splint, but in those cases where the business of the patient demands his immediate presence he is enabled, with his foot encased in a hard shell, to go to his office and perform the duties required of him.

Latterly I have used these appliances with great satisfaction, and, as I relate the following cases, shall point out a few "tips" in the application and removal of the apparatus. There are many ways of using the plaster of Paris, but I think the following the most suitable plan: The limb should be encased in a large, thick, porous woollen stocking. A roller of book muslin, the coarser the better, about 2½ inches wide, should be wetted and applied around the leg in the ordinary way. There should, however, be no "reverses" made in the bandage. At every third or fourth turn, water and dry plaster should be alternately rubbed over the limb. This process is to be continued until a thick layer of bandage

and plaster envelops the limb from the toes half way up to the knee. Every now and then thin slips of wet cardboard should be inserted between the layers of bandage to strengthen weak places, such as the back and front of the joint, below the heel and the ball of the great toe. The splint completed and the plaster set, the patient may be allowed to walk in a few hours, or perhaps the next morning. In a week the splint may be removed, passive motion employed, and the shell kept at hand ready to be reapplied whenever any unusual strain is to be put upon the joint, or be used in the daytime and removed at night.

*Case 1.*—Mary H., æt. 26, a parlour-maid, slipped on the pavement on the 21st October, 1879, and sprained her left ankle. Twenty minutes afterwards there was very great swelling over the external malleolus. Intense pain. Applied with firm pressure two or three rollers of common gray cotton bandage soaked in iced water, about the ankle, so as to form a stiffish casing for it. Iced water was applied during the night. On the following morning the swelling had almost disappeared, but there was great pain on the slightest motion. The splint was applied in the manner described. As soon as the plaster had hardened, the girl was able to get up and walk about her room without pain, and on the following day was able to attend to, at least, a considerable part of her duties. In a week the apparatus was removed, and she found the ankle quite well. In the removal of a plaster splint there is usually a deal of bungling. The best plan is to divide the splint down the front with a small saw. Some pocket-knives contain a little saw useful for this purpose. The stocking used by this patient was strongly "rubbed," and made little ecchymoses on the skin.

*Case 2.*—George R., æt. 16, a schoolboy, was engaged in a football match on the 9th of October, 1880, and received some injury, he knew not how, of his ankle joint. About half an hour afterwards there was very extensive swelling all around the joint, but more especially about the external malleolus. In fact, it was impossible at the time to tell whether the fibula had escaped fracture. The limb was put up in a wooden side splint, and lead and opium

lotion applied. For two days the swelling was so very great that it did not seem desirable to apply any fixed apparatus. On the fourth day the plaster bandage was applied. Here I neglected two important points. The plaster set while the foot was not quite at right angles with the leg—consequently the toes pointed downwards slightly; moreover, I neglected to cover the heel thickly enough. As a consequence, the weight of the body was thrown too much forwards and the patient did not walk without pain. These defects were soon remedied. The boy slept well all that night, it being his first night's rest since the accident. In a few week's time he was able to walk about his house, and soon extended his promenade to the garden. Although complete recovery did not occur for some four weeks, I have no doubt but that under other plans of treatment he would have been in bed some weeks suffering pain and ennui, and have gone back to school in three months with a weakened ankle. At present he can take part in all the sports becoming his age, and I find that since the winter set in he has been skating every day.

*Case 3.*—A stout cook, aged 40, missed a step in coming down stairs. Twenty minutes afterwards there was a swelling the size of a very large apple over the centre of the ankle joint. I had no bandage with me but book muslin. This was wetted and applied directly to the foot with considerable pressure. This bandage being firmly impregnated with starch in drying, forms a firm light casing. She was told to remove it should there be pain during the night. Immediately after the application she felt quite free from pain, but during the night she became frightened, thinking that gangrene was setting in, being of a nervous disposition and an old maid; so she cut part of it off. The following is an extract from my case book. "Nov. 5th, 1880 (the day after the accident).—All swelling gone. Not much pain but great weakness is complained of. Complete inability to put the foot upon the ground. Encased the joint in plaster in the usual way. Nov. 7th, 1880.—Very comfortable. Able to do work and walk about the house. Complains of pain towards evening (she had previously suffered from swelling of the feet at night time). Nov.



10th.—Removed splint with saw. Patient able to walk about without splint." Thus in a week she was completely set upon her feet.

*Case 4.*—On the 5th November, 1880, I was called in the greatest haste to see a man whose leg was said to have been broken. I found a burly brewer's driver, about 22 years of age, surrounded by friends, and groaning with pain. He had been scuffling, half in fun, half in earnest, with a fellow-workman, and had received an injury of the right ankle joint, he did not exactly know how. A swelling as large as an orange covered the external malleolus. No fracture could be detected. Applied common rollers soaked in iced water. The next day, having forgotten my plaster, I applied a starched bandage. On the following day I found him walking about the yard, playing the trombone. On the sixth day he was back again at work. Starch does not answer well for this purpose, as it takes too long to dry.

It is obvious that great care must be taken that the joint be not kept too long fixed. After a week the splint should be removed, and applied only when the patient is obliged to undergo some extra exertion. Sir James Paget (*Clinical Lectures and Essays*, p. 96) states that too long rest is by far the most frequent cause of delayed recovery after injury of joints in nearly all persons who are not of a scrofulous constitution. Mere long rest, he says; stiffens them and makes them over-sensitive, cold douches and elastic restraints and pressures make them worse; and nothing remedies them but movement, forced or voluntary. He tells us, too, that such are the cases successfully treated by bone-setters, who get a joint that has been sprained and kept too long at rest; then, pretending or believing that it has been dislocated, wrench it, and tell the patient that it has been put in, and that now he may use it.

I have no doubt but that many of those who take the trouble to read this communication will say that I am deceiving myself by the *post hoc* argument. These cases were all severe ones. I have treated cases by the older methods, and have reason to know how long such cases last. I have seen a patient, a strong young man, lame for upwards of six months from the

effects of a simple sprain. I may here throw out a suggestion that practitioners will find, in many instances, that book-muslin is a great improvement on gray cotton as a bandage for common use. Some weeks ago I used it on a Colles' fracture. It is well starched, and, when applied wet, sticks firmly to adjacent parts, making a stiff, firm covering. It cannot stretch or get pulled out of place, is porous, light and comfortable, and is not more expensive than the common article.

1433 St. Catherine Street, Montreal,  
January 14th, 1881.

### FRACTURE OF THE SKULL, WITH A COMPLICATED FRACTURE OF THE LEFT FORE-ARM—RECOVERY WITH UNAVOIDABLE RESULTS.

BY C. FREEMAN, M.D., MILTON.

The case which I am about to report is intensely interesting to the profession in two particulars: firstly, its being of extremely rare occurrence; and secondly, from its having formed the subject matter of a supposed case of malpraxis.

#### ACCIDENT.

Duncan Tost, æt. 14, carpenter, while assisting his father in the erection of the new Town-hall at Georgetown, fell, on the morning of the 17th of August, 1878, about 22 feet, with a pair of rafters in his hands, on the hard floor, his head striking against a scantling. The results were fracture of his skull above the left orbit (with both concussion and compression of the brain), also fracture of the radius and ulna in their lower third, with rupture of three of the tendons of the flexor sublimis digitorum at their attachment to the muscle, and severe contusion of the other flexors. There were no abrasions of the skin at the seat of either fracture. Drs. Wm. Freeman, Standish, Starr and Rannay were summoned immediately, and found the patient apparently lifeless, with little or no prospect of recovery. After the free use of salts of ammonia and other stimulants, Dr. Freeman reduced the fracture of the arm and applied Day's splints. He then cut down and elevated the depressed bone of the skull with the assistance of the medical gentle-

men present. The patient was seen three times the day of the accident, and the arm was dressed during the evening. The boy was in a semi-comatose state for a few days, and required the use of the catheter. The arm and head were dressed daily, and the patient was visited twice and thrice daily for two weeks, and afterwards once a day until the 7th Oct. Drs. Rannay, McGarvin, and C. Freeman saw the boy in consultation at different periods within ten or twelve days of the receipt of the accident, and corroborated the defendant's testimony at the trial, that at no time was there a solitary condition present to indicate gangrene from too tight bandaging, but the deep-seated suppurative inflammation arose from rupture and contusion of the tendons from the severity of the accident. About the beginning of the second week a fistulous opening made its appearance over the seat of fracture, and gradually enlarged upwards until three of the tendons dropped down and were removed about the third week, when Dr. McGarvin saw the patient again with the attending surgeon. About the time the suppurative inflammation commenced, the anterior splint was removed and never used again, the bandage having been applied around the palm of the hand and up the arm, leaving an interspace of about four inches for local applications over the seat of fracture. After the *debris* was removed, it healed kindly, with the following results: a perfectly straight fore-arm, with partial contraction of the fingers, caused more particularly by the adhesions and contraction of the profundus digitorum. The patient was requested to persevere with passive motion, which pained him so much that he could not do so. At one time the parents desired Dr. Freeman to remove the hand, which he declined to do stating that it would be impaired, but would be better than an artificial one. No dissatisfaction was expressed until after the doctor had sent his bill, when the ungrateful father manifested his admiration of the doctor's skill and attentive kindness by instituting a vexatious suit at the Milton Assize Court for \$5,050, in September last, for negligence and want of skill during the treatment of his son. In consequence of the delay in obtaining the

preliminary examination of the patient before His Honour Judge Miller, of Halton, Chief Justice Wilson granted the application for changing the venue to the city of Hamilton Assizes on the 25th of October. Notice was given for trial and expenses again incurred, and then it was countermanded. The gist of the boy's evidence before Judge Miller was, that he was faithfully attended by Dr. Freeman; his hand and fingers were never swollen, benumbed or discoloured; and that his fingernails were natural, and did not come off. He wanted money for the partial loss of his hand. The trial finally took place on the 5th and 6th of January, 1881, at the city of Hamilton, before Mr. Justice Galt. The chief contention on the part of the plaintiff's counsel, Messrs. Hagel and Schoff, was that the arm was not dressed for eight days, and that the deep-seated suppurative inflammation arose solely from the splints and too tight bandages, through the culpable negligence and want of skill of the defendant. This was very inadequately supported by the lay testimony of the Tost family and friends, with the professional evidence of Drs. Standish, Starr, DeLa Haye, Bennett and Hagel; while, on the other hand, the defendant's counsel, Messrs. Goodwillie, Laidlaw, and Osler, contended that there was neither neglect nor want of skill in the treatment of the patient, which was clearly and conclusively established not only by a number of disinterested and respectable lay witnesses, but was further ably and unanimously confirmed by Drs. Canniff of Toronto, Ridley, Billings, Miller, Mackelcan of Hamilton, McMahon of Dundas, Buck of Palermo, McGarvin of Acton, and C. Freeman of Milton. The judge's patience was sorely tried and almost exhausted by the hesitancy and delay on the part of many of the medical witnesses for the prosecution, when he put this important question to them: "Would not deep-seated suppurative inflammation which lasted for months be more likely to occur in a broken limb from internal injury or contusion than from any subsequent bandaging or splints?" His Lordship, after passing a very high encomium on the medical profession and its advantages to the public, animadverted in the strongest terms on the great ingratitude of the plaintiff, and the vexatious injustice and great expense sustained by the defendant in consequence of the suit.



## PECULIAR CASE OF CHANCROID.

BY GEO. WRIGHT, A.M., M.D., TORONTO.

The following case of chancroid, that came under my notice, possesses one or two points of interest, and I have thought it proper to communicate it to your Journal.

Thomas O——, age 13 years, came to my office with his father on the night of the 18th of November. The father informed me that his son had fallen on the wheel of an express waggon and received an injury, about which he desired to consult me. From previous intimations I had received in another place, I was not altogether unprepared for another illustration of those cartwheel cases, which have become somewhat traditional, and in which the member next most unruly to the tongue was possibly implicated. I at once suggested to the youth that he should "*show up*." In consequence of his tender years, I avoided any expression of my apprehensions to the boy, until quite satisfied that, in challenging him with indiscretion, I would be doing him no injustice. And here I venture to make a suggestion, without desiring to read a lecture to my professional brethren. My experience with all such cases of youthful depravity has been, that the slightest levity in the presence of those concerned has a demoralizing influence, by encouraging them to think that, after all, their case is not so shocking.

I found, on examination, a chancroid involving the whole point of the *glans penis*, being about the size of a five-cent piece, and situated more to the left of the *meatus*, but still covering it. There had been considerable swelling and pain of the right inguinal glands, which had partially subsided before I saw him.

On inquiry as to the origin of the trouble, the boy stoutly protested, at first, his innocence of any indiscretion. But, after a good deal of beating about, until he found that any further attempt at concealment of the facts might be a serious impediment to his recovery, I elicited the following facts. This boy, with four others of about the same age, were out together in the evening about a fortnight before I saw him; and on one of the leading streets of the city they came in contact with four little girls

of ages from eleven to thirteen. He represented that he and his companions had been seduced by those little girls, and that they retired to a vacant lot in the neighbourhood, where they had a short season of mutual intercourse, and finally separated. The boy declares that his little paramour was not more than twelve years of age, and that he must have contracted the disease from this mere child. I am told that such cases are not at all uncommon in this city; but I am happy to say that, in my thirteen years' experience, I never before met with one in whom this or any other form of venereal disease was developed at so early an age.

A noteworthy feature of this case was the fact that the threatened lymphatic glandular trouble was on the side most remote from the chancroid.

The case improved rapidly under local treatment, consisting of carbolic acid lotion, one in thirty-two, with the observance of scrupulous cleanliness; and in ten days the sore was entirely healed.

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TRIPOLITH DRESSINGS.—A new compound material (preparation secret) whose main ingredients are calcium, silicium and protoxide of iron (*International Medical and Surgical Journal*), has been introduced by V. Langenbeck of Berlin, as a substitute for plaster of paris, which it resembles in appearance and weight but, is smoother and softer. It is used in exactly the same way, and the advantages claimed for it are: that it absorbs less moisture from the air, and consequently keeps better; dressings made with it are lighter; they harden more rapidly, and once hardened take up no more water; it costs a trifle less than plaster of paris. The name proposed for it is tripolith (or triple stone), from its great hardness. It is shipped from Hamburg.

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THE EDINBURGH COLLEGES.—A movement is again on foot in Edinburgh to wipe out a disgraceful blot in the constitution of both the Royal College of Physicians and the Royal College of Surgeons, and to put an end to the admission of members and fellows except upon due examination. The agitation has, however, we believe, excited much opposition.

## Selections: Medicine.

### CASE OF PYOPNEUMOTHORAX SUB-PHRENICUS.

Prof. Gardner, McGill University, reported an interesting case of sub-diaphragmatic abscess and pyopneumothorax (so called) before the Medico-Chirurgical Society of Montreal.

A young man, *æt.* 28, of rather delicate health, had an attack of perityphlitis which developed into general peritonitis with very alarming symptoms. Contrary to expectation, he rallied, and most of the abdominal symptoms disappeared, with the exception of tenderness in the right iliac and lumbar regions. No distinct swelling could, however, be detected. In a few days he felt pain in right side of chest, involving lateral and front parts up to fourth rib: no dulness on percussion, no pleuritic friction sounds, but weak respiration sounds over anterior and lateral parts of the right lung. Temperature occasionally rose—sometimes diarrhoea.

• Suddenly, in seventh week of his illness, and two weeks before he died, he was seized with sharp pain in his side, and began to cough up pus, which was soon replaced by a brownish fluid having all the characters of thin *fæces*. Semi-collapse followed, and on physical examination of the chest a remarkable change was found to have taken place. The physical signs of air and fluid in the right thorax had developed themselves, in, however, a somewhat modified form. As the patient lay on his back, percussion of the right side gave forth, from the third interspace downwards, to the lower edges of the ribs in front, and at the side, a clear tympanitic note. Above the third interspace the note approached in character the ordinary healthy note. At the dependent part of the chest, as he lay on his back, the note was perfectly dull. By turning the patient on his left side, the limit of tympanitic note on percussion was altered. All the parts of the right chest now uppermost were tympanitic when percussed, showing the presence of air and a liquid. Nowhere, in any position, could the liver dulness be discovered; neither could the liver be felt by palpation. On auscultation,

weak, amphoric respiration was present from the third interspace downwards; on coughing, splashing sounds. Above third interspace the respiratory sounds approached in character the vesicular murmur of health. There was considerably diminished mobility of the right chest wall, which was quite sensitive to the pressure of the stethoscope. A normal condition of the intercostals obtained. Seen at various times in consultation by Drs. Fenwick, Buller and Ross. Diagnosis: perityphlitic abscess communicating with the bowel, creeping up behind the peritoneum and perforating the diaphragm, and thus gaining access to the cavity of the chest, and subsequently perforating the lung. During the last fortnight that he lived the patient coughed up at intervals pus, and the thin, brown, stinking fluid above described. There was great debility and frequent diarrhoea. Died in a paroxysm of coughing.

Autopsy, fifteen hours after death, by Dr. Rich. MacDonnell. Emaciation extreme: on opening the abdominal cavity, the first thing noticed was the absence of the liver from its natural position. It was pushed upwards, backwards and inwards towards the spinal column, completely away from the right lateral and anterior chest wall, thus explaining the impossibility of either feeling or discovering it by percussion. To the outside and behind the cœcum an abscess cavity was discovered, having on its inner wall the appendix vermiformis, containing a number of masses of inspissated, quite hard, *fœcal* matter. Two or three openings existed between the cœcum and this cavity, one of them being large enough to admit the little finger. This cavity communicated by a narrow neck-like prolongation, extending upwards behind the peritoneum, with a very large cavity, probably as large as a child's head, bounded above by the diaphragm pushed up to the level of the third interspace; externally and anteriorly by the ribs, as far as their free edges; below and on the inner side by the right lobe of the liver, whose upper surface and free edge, compressed, flattened, and rendered quite obtuse, formed part of the wall of the abscess cavity. The contents of this cavity were not pus, but a thin, brown-colored, stinking fluid,



containing flakes of curd of milk, and gas or air. The stomach was somewhat pushed over to the left. The transverse colon was somewhat displaced downwards. The right lung was much compressed, its lower lobe collapsed and closely adherent to the diaphragm; a series of perforations existed, extending through the lung substance to the bronchi. There was no effusion in the right pleural cavity. The left lung was healthy; the heart healthy, a little displaced to the left.—*Synopsised from Canada Medical and Surgical Journal.*

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### Surgery.

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#### FRACTURES OF THE INFERIOR EXTREMITY OF THE RADIUS.

M. DUPLAY.

Fractures of the inferior extremity of the radius are easily recognized and are generally produced by a fall on the palm of the hand. The physiological signs are an impotence of the limb and a violent pain at the wrist. The physical signs are of much greater importance and are truly pathognomonic. They are characterized by a deformity of the wrist, easily produced on the cadaver, and by a vicious attitude of the hand.

The dorsal deformity gives to the wrist the aspect of a fork handle, as Velpeau described it, or of a Z. On the palmar aspect the deformity is in an inverse direction; on the lateral parts the styloid apophysis of the ulna is sometimes broken off. It makes a more considerable protuberance than in the normal state on account of the displacement *en masse* of the hand. The styloid apophysis of the radius is shoved upwards, and is found on the same plane as the styloid apophysis of the ulna; while in the normal condition it is situated lower, and beneath this last.

Lastly, the vicious attitude of the hand is such that the entire hand is pushed from the ulnar towards the radial border; and the prolonged axis of the forearm, in place of being normally continuous with the axis of the middle finger, passes, on the contrary, into the axis of the ring finger.

These different deformities that we have just indicated, as well as the vicious attitude of the hand, caused the belief for a long while, even for some hundreds of years, in a luxation from before backwards of the hand, and from behind forwards of both bones of the forearm. It was only at the beginning of this century that the error was recognized.

Luxation of the hand is, moreover, very rare and its diagnosis easy. The protuberance backwards is altogether different from that which is produced by fracture of the radius. It takes on the rounded form of the carpal bones, very distinct from the irregular surface formed by the fractured extremity, dentated and unequal. Further, in fractures of the radius, the styloid apophysis is displaced from its relations, whilst in luxation its relations are the same. Its diagnosis is then, I repeat, very easy; and further, this luxation is so rare, that hardly one example of it is observed, against five hundred fractures of the inferior extremity of the radius.

Now there are cases in which fracture of the radius is not accompanied with displacement, or where this is so feeble that it is scarcely perceptible; further, an error is committed even in these days, the pain and impotence of the limb causing the supposition of a sprain of the wrist. The diagnosis between sprain and fracture is sometimes more difficult than between luxation and fracture without displacement. This diagnosis rests upon three symptoms which we might call fundamental. The first is the seat of pain on pressure, which in a sprain is found at the level of the radio-carpal articulation and of all the carpal articulations, or a little beneath this interline; whilst in fracture it is situated a little higher, above, the line of articulation, and the pain is less intense at the level of the carpus.

The second sign is furnished by the relations of the styloid apophyses of the radius and ulna to one another, which are no longer the same as in the normal condition, even when the fracture is accompanied by no displacement. The third sign is the mobility of the fragments, slight as the displacement may be, when in cases of fracture antero-posterior movements are instituted.

Thus, then, the seat of the pain, abnormal mobility and change of relation between the two bones of the forearm : such are the distinctive characters of fracture of the inferior extremity of the radius.

The inferior fragment of the fractured radius is generally very short, and the seat of the fracture is most often found at a centimetre and a half above the articular interline. The direction of the fracture is nearly transverse; and the extremity of the superior fragment, pointed, frequently penetrates the extremity of the inferior fragment, which it sometimes splits, producing secondary fragments. It is when the carpus is displaced with the inferior fragment of the radius, the hand being carried towards the dorsal face of the forearm, whilst the superior fragment protrudes on the palmar face, that results the fork-handle of which I spoke in the beginning.

The first effects of the fracture—especially in the case of penetration of the bones—are a shortening of the radius, an ascensional movement of its styloid apophysis, the apparent protrusion of the styloid apophysis of the ulna, and the deviation of the hand on the radial border of the forearm. There exists little or no crepitation of the bony fragments.

Fracture of the inferior extremity of the radius is produced almost always in the same conditions by a fall forwards on the palm of the hand, the heel of which supports the wrist. Its mechanism, which no author has been able, until lately, to give very clearly, and which I confess I had never, so to speak, understood before becoming a surgeon of the hospitals, is the following :—

The individual falls from a height more or less great, or from his own height, and the fracture is produced by pulling; the anterior radio-carpal ligament being forcibly stretched by an exaggerated extension. This ligament is inserted fifteen millimètres above the articular interline; and it is nearly at its level, or a few millimètres above, that the fracture is produced, and its form corresponds to that of the inferior insertion of that ligament. A *memoire* of Dr. LeBon especially suggested this mechanism, which is to-day absolutely demonstrated.

It is then always by pulling that this fracture is produced. If it took place in an inverse sense it is still by the same process, by the pulling of the posterior ligament, which pulls in its turn the portion of the radius to which it is inserted. This mechanism is most important to comprehend perfectly, in order to prepare for the deformities which the fracture brings with it and the accidents which may follow it.

As to the displacement, it varies according to the age of the subjects. It is much rarer after fifty years than under that age, for a reason easy to understand.

At that age, in fact, the bones have undergone modifications of structure characterized in the inferior extremity of the radius, as in the neck of the femur, for example, by a superabundance of spongy tissue: consequently, it is sufficient then for a slight fall upon the palm of the hand to produce a fracture of the radius. If the violence is slight, the displacement is nothing as well as the deformity. On the contrary, in young people and children, the fracture exacting a certain amount of violence for its production, necessarily carries in its train a deformity of the limb and a displacement proportional to the violence which caused the fracture.

Fractures of the inferior extremity of the radius easily recover without accident unless, unrecognised, they also are badly treated, and a vicious consolidation allows a deformity to persist, which is shameful, not only in an æsthetic view, but also because by it the limb loses its strength and the hand its skill.

If there exists no displacement, any retentive apparatus is good, and consolidation is effected in twenty-five days. I generally apply a plaster splint, which I take away the twenty-fifth day, after which I begin to make some motions of the limb.

If, on the contrary, the fracture is accompanied by displacement, it is very necessary to proceed to its reduction. Chloroform is rarely necessary, unless the patients are extremely nervous, pusillanimous, or of an exaggerated sensibility. Reduction being obtained, the fracture is placed in a plaster apparatus, of which the splint will encroach a little on the external lateral face of the forearm and the hand, which will be left pendant. As to the consecutive articular stiffness, it generally disappears in less than a month by massage and douches.—*Gaz. des Hôp.*



## Midwifery.

### PUERPERAL ECLAMPSIA.

BY WM. H. WATHEN, M.D.,

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(REPORTED BY A. H. KELCH, M.D.)

There is a great variety of opinion in regard to the treatment of puerperal eclampsia, and you can see at once why this should be so, because there is no settled opinion in regard to its cause. You know the scientific treatment of disease is to first discover its cause, and then remove that cause, if possible; and where that cannot be determined, we must simply use those remedies which, in the hands of the most experienced physicians, have yielded the most successful results.

In studying the statistics of all the past cases that were available, it was discovered that about thirty-two per cent. of those cases that occurred subsequently to labour ended fatally; but in the examination of cases that have occurred since the subject has been more thoroughly studied and the treatment more successfully adapted to the case, we find the mortality has very materially lessened, and that it does not exceed fourteen per cent. in scientific hands; and I predict that in a very short time it will not exceed ten per cent. in all cases.

Now, one of the old remedies, one that was for some time discontinued in this country, but which has to some extent been reintroduced and recommended, is venesection as soon as the attack is discovered.

Venesection is unquestionably a decided benefit at the beginning of and during an attack, when the symptoms are violent, and the face and brain much congested. This is demonstrated by clinical experience, for we frequently find the attack thus cut short, and no recurrence of it for a considerable time.

Granting that the blood is in a hydræmic condition, still there is an excessive vascular tension; and we can readily comprehend how venesection should be immediately productive of happy results, preventing serious lesion of the brain and kidneys by relieving vascular tension; and we can at the same time understand how excessive venesection, or venesection

practised indiscriminately, could be productive of evil results; for when you remove the blood, you remove not only the watery elements, but, simultaneously, a proportionate amount of the blood corpuscles that are necessary to the sustenance of the patient; so that, while you relieve that excessively vascular condition, while you remove the immediate danger of structural lesion of the brain and kidneys, you leave the system in a condition that is less favourable to recovery than it would otherwise have been; and it often does not afford permanent relief to the vascular tension, because the blood has the power to absorb from the tissues the watery elements, and thus produce the same amount that existed previous to the venesection. So, when you bleed, do not practise it to excess. Venesection may produce permanent good results, or be of temporary benefit that will enable you to avail yourselves of other treatment, by which you may bring about rapid and favourable results.

When you have controlled the immediate convulsion, then you may resort at once to other treatment to prevent a recurrence, and the best of all remedies is chloroform. It gives the best results, and having put your patient at once under its influence, you can administer it during the convulsion, and during the coma at any time that it is indicated.

There is no necessity for thoroughly anæsthetizing your patient, but give enough to control the convulsion, and when it begins to reappear, increase the amount until it is controlled. It must be watched closely and continued for a long time. It is well, when you have once commenced it, that you should administer some remedy that is more pleasing and lasting in its effects, and nothing more fully meets this double indication than full doses of hydrate of chloral.

You may combine large doses of bromide of potassium with it.

Dr. Barker has not experienced the happy results from chloral which have been met with by a great many celebrated authorities upon this subject, and he advises, in its stead, large doses of morphia hypodermically. The chloral may also be administered in this way, giving from four to eight grains in one drachm of water as often as may be indicated.

After the convulsions are brought under control, a brisk cathartic should be given, that will, as soon as possible, clean out the bowels and cause a watery discharge; because in this way you deplete, by relieving the vascular tension without removing the blood elements.

Accepting the theory of the hydraemic condition of the blood, we would naturally expect to have happy results from those remedies that produce profuse diaphoresis. But we find the results have not been in accordance with this theory, and we have, by the use of pilocarpine administered hypodermically, unfavourable reports—indeed, quite a number of fatal results, and it has been determined that under the use of pilocarpine, where salivation has been produced, the success has been less encouraging than where we have resorted to the other means of treatment I have suggested.—*Phil. Med. and Surg. Reporter*.

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### Translations.

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It suffices, says M. Lépine, to vary the degree of acidity of the urine examined, in order to obtain at will retractile or non-retractile albumen.—*Le Prog. Méd.*

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#### CUTANEOUS HYPERÆSTHESIA DUE TO DYSPEPSIA.

M. Leven has studied the influence of dyspepsia upon the sensitive nervous system and upon the motor nervous system. All the classical treatises repeat, on the word of M. Briquet, that hyperæsthesia of one-half the body is a frequent complication of hysteria, and that in hystericals the hyperæsthesia occupies by preference the left side. M. Leven believes that this phenomenon depends rather upon stomachal troubles. In fact, hyperæsthesia is met with eight times out of nine in dyspeptics, as well in men as in women. The degree of hyperæsthesia is more over in proportion to the intensity of the disease of the stomach. Hysteria develops not hyperæsthesia but anæsthesia. This is so true, M. Leven declares, that the coincidence of hyperæsthesia of one side and of anæsthesia of the other side in the same patient indicates at once dyspepsia and hysteria.—*Le Prog. Méd.*

#### LOCALIZATION OF PAIN IN HEPATIC COLIC.

BY J. CORNILLON.

1st. *Cystic Point*.—Anatomically, it corresponds to the place where the gall stone leaves the gall bladder to pass the cystic duct and become engaged in the choledoch canal. According as the calculus approaches the duodenum and the *ampulla* of Vater this painful point is extended, and soon ends by becoming confounded with the epigastric point.

Nearly constant, it is wanting however in some fine attacks of hepatic colic with icterus and issue of biliary gravel; or it is so slight as to pass unperceived both by the patient and the physician. It is very difficult to determine the sensations to which it gives rise, its forms are so varied. Sometimes it is acute and tearing, and produces cries and tears; sometimes it is comparable to a heavy body which compresses the right hypochondrium. Its intensity depends neither upon the length nor the brevity of the attack. I have seen it very acute in short crises, and slight in crises of long duration: in other cases, I have remarked that the expulsion of large biliary calculi gave rise to supportable cystic pains, whilst small concretions occasioned horrible sufferings. It is a matter of idiosyncrasy.

The cystic point is direct; its position at the beginning is very nearly fixed. When I have investigated it, I have seen that it corresponded, most often, with the inferior border of the great lobe of the liver, below and to the right of the xiphoid appendix, at about ten centimetres from the point of that bone. By sliding the pulp of the index finger between the border of the costal cartilages of the right side and the anterior abdominal wall, we may proceed to determine it with most exactness. In certain cases the cystic point is displaced: it is found in the seventh or the eighth right intercostal space, on a line which leaving the right nipple would follow a direction parallel to the median division of the body. Finally, in some circumstances, it is a little outside of this line, four or five centimetres at the most.

This painful point, even when it is slight, is always accompanied by trouble in the



respiratory functions—the patient suffocates. This dyspnoea, which might cause us to look for an unexpected complication of the pleura, or of the lung, or of cardiac troubles, is nothing but natural. Physiology explains it to us. When the diaphragm contracts in inspiration, the liver is slightly lowered, to be raised again in expiration. The movements of ascension and descent of this organ necessarily exaggerate the cystic pain. Instinctively then the patient abstains from breathing. That is the whole secret of this dyspnoea.

The cystic point announces the near apparition of an hepatic colic, sometimes twenty-four hours before the appearance of the other accidents. It is then a sign of a certain value. Not always disappearing with the end of the attack, its persistence for days and even for some weeks, indicates either the return of the colic in a short while, or the existence of a cholecystitis. These indications are precious, as well for the prognosis as for the treatment of the principal affection.

Pointed out for the first time by Flemming, this painful point is not admitted by all authors, and notably by M. Charcot. In my opinion he is wrong.

2nd. *Epigastric Point*.—This is never wanting, so that all the authors who have in any degree whatever busied themselves with the biliary lithiasis, describe it. Pemberton and M. Sénac (of Vichy) speak of it in their writings. Purely reflex in nature, it appears after the beginning of the morbid accidents, and although the stomach may be struck only by *contre coup*, it makes itself felt the most acutely and attracts the attention of the physician the most. Sometimes it consists of a sense of dilatation and distension of the stomach, in a cramp, sometimes in a bar which extends from the border of the left false ribs as far as that of the ribs of the opposite side, thus dividing the stomach into two equal parts. Sometimes this bar has a direction diametrically opposite; it starts from the xiphoid appendix and ends at the umbilical ring. Here, it is a weight which compresses the epigastric region; there, it is a sensation of scalding and of a dragging at the level of the stomach.

These varieties of pain, so dissimilar in appearance, have however one common point, which is, that their maximum point is found quite exactly in the median line of the body, and at one or two finger's breadths beneath the xiphoid appendix. The epigastric point is accentuated according as the attack augments, so that at the moment of its paroxysm, it occupies the whole region of the stomach and seems to be confounded with the cystic point. Until then, pressure upon the epigastrium was possible; but at this moment epigastralgia supervenes, and palpation even is no longer practicable without causing the patient to utter sharp cries. The unfortunate ones cannot bear the slightest touch in this place. They throw off their covering and avoid even the contact of their shirt. If they are in bed they assume the position most suitable to alleviate their sufferings. This position is essentially variable according to the case. When they make a movement they execute it, as it were, all of a piece. If they are up, they bend themselves forwards with the hand in front of their epigastrium, as if to sustain it and protect it from external objects. Others, on the contrary, experience relief by compressing the stomach with the fist, or by applying warm bodies on the painful spot.

At the moment when the cardialgia appears, nausea supervenes with emission of fetid gas, and soon after the desire to vomit emesis occurs ordinarily. In the beginning it takes place without effort: the patients reject their aliments without experiencing very great suffering; some even imagining that they have an indigestion (which often happens with those who are taken for the first time with similar accidents), thrust their finger down their throat or swallow some tepid water to aid the vomiting.

Once the stomach is emptied, there is a slight relief; but it is of short duration, for the vomitings soon recommence. They are no longer executed as before, without pain and without fatigue; often, in fact, they are accompanied with anguish, with lipothymia and even with syncope. The matters rejected are bilious, mingled with glairy mucus and with the débris

of food which had resisted the previous evacuations.

As soon as the crisis diminishes in intensity, the violence of the epigastric pain is less, and often even it ceases with the end of the access, unless a local or general peritonitis should intervene. However, there exist numerous cases in which, in spite of the cessation of the hepatic colic, and without any phlegmasia whatever being declared, the cardialgia is renewed for many days after the patient takes a little nourishment. This persistence can be explained only by the continuation of the reflex action which has been exerted upon the stomach.

3rd. *Dorsal Point*.—Its existence was pointed out for the first time by M. Vidal, in a communication to the Society of Biology. He calls it point of correspondence, and places it over the spinous apophysis of the fourth dorsal vertebra.

Upon many occasions it has been permitted me to point out the dorsal painful spot. Generally, I have found it comprised between the spinous apophysis of the seventh dorsal vertebra and that of the tenth; very exceptionally, it is higher or lower. It corresponds exactly to the epigastric point in such a manner that, if we were to introduce a needle at the latter point, making it to follow a horizontal direction, the spinous apophysis where it emerged would be found to be the maximum of the painful dorsal point.

It is at the very beginning of the hepatic colic that it appears with the cardialgia and the gastric troubles, and it ceases with the end of the principal lithiasic accidents. It is rarely wanting even in the slightest cases. It acquires sometimes such intensity that the patients are obliged to bend themselves forwards to lessen its violence. The pain is spontaneous, as in the cystic and epigastric points, but it is exaggerated by pressure; and when we lean upon the spinous apophysis, it causes a sharp crushing feeling, accompanied by cries and propulsion of the body forwards.

The dorsal painful point ought not to be confounded with the general feverishness which follows hepatic colic; it is due to the osseous system and not to the muscles. A little

attention will always suffice to prevent a mistake.

4th. *Scapular Point*.—This is far from being as constant as the preceding; in fact, we meet with it only in about one-fifth of the cases. To Budd belongs the honour of its discovery. Generally it is at the inferior angle of the scapula that the pain is felt most sharply. At times also it is localized in the acromion or in the spine of the scapula, in such a manner that its seat is not absolutely fixed and constant. This point is very painful. It is exaggerated by pressure upon the osseous surfaces and by the movements of the shoulder. It is accompanied at times by strange troubles, tinglings in the ends of the fingers of the right hand, by sensitiveness of the bones of the elbow, and notably in the epitrochlea. These last phenomena may even be manifest in its absence.

The scapular point is a manifestation of hepatic disease, so when it exists it is a valuable semeiological sign. It permits, in fact, a strict and precise diagnosis in all cases in which there is hesitation between the biliary and renal lithiasis.

5th. *Painful Point of the Left Hypochondrium*.—Of all those which we have just pointed out, this is by far the rarest. Denied by M. Sénac, it is admitted by MM. Durand-Fardel and Willemin, who have observed a certain number of cases of it. It is found situated a little below the border of the left false ribs, below and outside of the xiphoid appendix, at about twelve centimetres from that bone.

Does this painful point proceed from a congestion of the liver or of the spleen? M. Willemin reports a case of sharp suffering localized in the left hypochondrium, in which the middle lobe of the liver and the spleen were engorged. Twice only have I met with this painful point, and in both cases the spleen was appreciably congested. I will even add that it was at its level that the maximum of suffering was found, so that I have asked myself if the painful point of the left hypochondrium was not rather a splenic than an hepatic point.

In acuteness it differs in no way from the cystic point. Like it, it forces cries from the



patient; like it, it sends painful irradiations to the epigastrium. When it exists, the attention of the physician ought to be awakened; for its proximity to the renal region and its extension into the left flank exposes to the commission of very prejudicial errors of diagnosis. They are even inevitable unless we can seize the *corpus delicti*.

*Nota.*—Sometimes the painful localizations of the epigastrium, of the back, and of the hypochondria are replaced by a cincture which enlaces the base of the thorax and constrains it. It is then impossible to establish any maximum whatever.—*Le Progrès Médical*.

#### RETRACTILE ALBUMEN.

The *Lyon Médical* publishes some remarks of MM. Cazeneuve and Lépine upon retractile albumen. These gentlemen consider that the retractility or non-retractility of albumen, in albuminous urine or other fluid, is of little pathological significance, and that it is dependent upon the chemical constitution of the fluid. Urine is said to contain retractile albumen when, upon the application of heat, the albumen separates in flocculi which contract, allowing the clear urine to be seen between and around the coagula; non-retractile, when only a turbidity or lactescence results. Both forms are frequently present at the same time, and may be separated by filtration. The addition of acetic acid, sufficient to saturate the alkalinity of the fluid, will cause the turbidity to disappear and the retractile form to appear—a little liquor potassæ or sodæ added to the albumen thus coagulated will cause the lactescence and turbidity to reappear. They explain this by the fact that the albuminous fluids of the body, in addition to free albumen, contain albumen combined with a base (potash or soda). These albuminates coagulate badly or not at all with heat, and hold in suspension the coagulated albumen; hence the turbidity. The acetic acid attacks the base, frees the albumen and allows it to contract; hence the retractility. Too much acid must not be added, as it has a tendency to re-dissolve the coagula.

## THE CANADIAN Journal of Medical Science,

A Monthly Journal of Medical Science, Criticism,  
and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, FEBRUARY, 1881.

#### ANTISEPTIC OVARIOTOMY.

Heretical opinion is undoubtedly contagious. When, therefore, a few months ago, Mr. Lawson Tait, of Birmingham, had the hardihood to appear in the midst of the Royal Medical and Chirurgical Society in London and denounce the practice of Listerism in ovariectomy as not only useless but injurious, we were not slow to foresee—notwithstanding the fact that not a single ally raised his voice in his support—that this seed of truth (as we believe) would not fail to fructify, even in uncongenial soil. Accordingly, we were not at all surprised to find Dr. George Granville Bantock, of the Samaritan Hospital, reading a paper at a late meeting of the Royal Medical and Chirurgical Society on “Hyperpyrexia after Listerian Ovariectomy.” This, with other symptoms of carbolic acid poisoning, appeared to be the main evil charged against the acid; and as one of its chief claims has always been the avoidance of pyrexia, the *tu quoque* retaliation was received with redoubled force. In the author’s experience 36 Listerian cases and 36 non-Listerian, gave a difference in temperature in favour of the former of but 0.4°; and the lowest temperature occurred after a non-Listerian case. Volkmann admitted a condition of phenic acid poisoning, and termed it “aseptic fever.” Thiersch had encountered great irritation from its use, and substituted salicylic acid. Keith found very little difference in the temperature in a series of cases under the old and the new methods. In three Listerian cases the temperatures were the

highest he (the author) had ever seen. Before adopting antiseptics he had never found the ice-cap necessary for subduing pyrexia. The experience of Mr. Spencer Wells and Mr. Knowsley Thornton was, however, contrary. The author described at length two cases of poisoning from prolonged action of carbolic spray in complicated ovariectomies. He had observed albuminuria and temporary suppression of the sulphates in the urine of a young girl after antiseptic ovariectomy. Sonnenburg, Lightfoot, and others had had similar experiences. The poisoning was not always indicated by discoloration of urine.

Mr. Thornton regarded the kidneys themselves as at fault in these cases, and strongly upheld antiseptics. In his last 100 cases he had had a mortality of 7 per cent. in hospital practice, and in private practice he had only lost 1 case out of 27. Without Listerism, the mortality in ovariectomy might be reduced to 10 per cent., but not lower.

Mr. Lawson Tait thought it impossible for anyone to understand the theory and practice of Listerism. He had used solutions of carbolic acid, gradually reducing the strength, till at last he used simple water, and had found that his results were equally satisfactory under the simple dressing. Moreover, under the latter, the wounds healed more satisfactorily; a fact which Dr. Savage, his colleague and a strong Listerite, felt constrained to admit. In one of his cases (double) the temperature rose to  $112^{\circ}$ , and remained so nearly 50 hours. He attributed this to the use of carbolic acid.

Mr. Spencer Wells said that since adopting the antiseptic method in 1878, he had had 131 cases with 13 deaths, or 10 per cent., the death-rate being exactly the same as in his last two years' of hospital practice without special antiseptic measures. Before, the results of the intra-peritoneal method had been less favourable than those of the extra-peritoneal; the reverse was now the case. He had never seen a remarkable rise of temperature after antiseptic ovariectomy; it rarely rose above  $100^{\circ}$ .

Mr. Holmes thought the statistics showed no decided difference in favour of Lister's method in ovariectomy. He had long ago tried,

without success, to master the details of the method, when they were more simple than at present; and he doubted whether anyone understood it in its present form.

Dr. Bantock, in reply, said his results had been as follows:—With 1 in 50 solution, 41 cases with 3 deaths; with 1 in 60, 10 cases and 1 death; with 1 in 80, 8 cases and 2 deaths; with 1 in 100, 19 cases and 1 death. In Italy, in the first 100 cases of ovariectomy (4 of which were done antiseptically) there were 37 deaths; in the second 100, done antiseptically, the mortality was 36. He had not been able to desist from the use of the ice-cap till he had reduced the carbolic solution to 1 in 80.

In an article in the *Berlin Klinisch. Wochenschr.*, 1880, 43, Prof. V. v. Bruns, of Tuebingen, following v. Naegeli, exclaims, "Away with the spray! not only unnecessary and superfluous, but also a disagreeable and annoying addition."

In the course of the debate at the Royal Medical and Chirurgical Society, Mr. Savory suggested that diminution of mortality in a surgeon's practice might be due, in great measure, to increased experience. And Mr. Lawson Tait regarded Mr. Thornton's great success as being attributable to the fact of his having been brought up under the master's eye during his long service with Mr. Spencer Wells. That this is the probable solution of all these differences receives strong confirmation from Mr. Tait's own record, seeing that he witnessed 19 deaths in his first 50 cases, and only 3 in his last 91. In the New York State Women's Hospital a death from ovariectomy is very exceptional, and yet, we believe, they are not Listerites there.

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Mr. W. G. Falconbridge, M.A., has resigned his position as Registrar of Toronto University. Messrs. W. H. Vandersmissen, M.A., Alfred Baker, M.A., and E. B. Brown, M.A., are, we believe, candidates for the office.

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Dr. Grant has been elected President of the Medical Society of Ottawa, and is spoken of for the vacancy in the Senate.



## ANÆSTHETICS.

The Report of the sub-Committee on Anæsthetics (composed of Prof. McKendrick, Dr. Coates, Dr. Ramsay, and Mr. Newman, of Glasgow) to the Scientific Grants Committee of the British Medical Association, published in the *British Medical Journal* for 18th Dec., 1880, affords the material, as well as a fitting opportunity, for the consideration of the merits as well as the demerits of the chief anæsthetic agents now in use. The effects of these were determined clinically by the committee in the wards of the Western Infirmary, Glasgow, and experimentally upon animals, for the most part frogs, dogs, and rabbits. As a result of their experimentation it became evident that chloroform exercised an injurious influence upon the respiratory centres as well as upon the heart, "while ether has no baneful influence" upon the cardiac contractions. The tardiness of the action of ether is, however, a great disadvantage; comparative experiments with rabbits showing that complete anæsthesia was induced with chloroform in about three minutes, while with ether 15 to 20 minutes were required, although the cloth was kept constantly saturated. Accordingly a trial of some dozen different agents was instituted with a view to discovering some anæsthetic possessing the advantages of both chloroform and ether with the disadvantages of neither. After a laborious and difficult investigation the committee reached the conclusion that the dichloride ( $C_2H_4Cl_2$ ) of ethidene—recommended in 1858 by Snow—possessed these qualifications in the highest degree. This substance, it appears, was used by Liebreich and by Langenbeck in 1870; Sauer also has recorded its use in 33 cases (two vomited, two suffered from headache, and one died from heart disease). Steffen has published the details of 20 cases with satisfactory results; and Mr. Clover records (*British Medical Journal*, 29th May, 1880) his experience of it in 1877 cases, with one death due to a fatty heart in which nitrous oxide had been previously administered. With reference to the comparative effects of ethidene and of chloroform in the human subject, the following facts are stated:—The average dose of ethidene is 40.3c.c.; or in other

words 1.8c.c. for each minute the patient is under the anæsthetic; whereas in the case of chloroform it is 31.8c.c., or 1.7c.c. per minute. Further, the time required to anæsthetise with chloroform is greater by 1.1 minute (5.4—4.3) than with ethidene. Again, recovery from chloroform anæsthesia occupies on the average 4.8 minutes; with ethidene only 4.4 minutes. Sickness during administration occurred more frequently with chloroform than with ethidene. The effects on the pulse respiration ratio are also tabulated. It appears hence that with chloroform there frequently occurs a rise in the respirations and a fall in the pulse below the normal line—these two phenomena being concomitant; moreover, dicrotism in the pulse and low arterial tension are not unfrequently observed. With ethidene on the other hand, there is but little disturbance of this kind; and in only one case did the pulse become dicrotic. The influence of these two agents upon the blood-pressure, and the effects of anæsthetics on the pulmonary circulation, are then dealt with by the committee; but of this portion of the report, and the ingenuity, patience, and labour expended therein, we can afford our readers no adequate conception, but beg to refer those interested to the No. of the *British Medical Journal* (18th December, 1880), in which it is contained. Suffice it to say, that in nearly all these respects, ethidene occupies a position midway between chloroform and ether. The recommendation of ethidene by the committee is so strong that we are greatly encouraged to urge upon members of the profession the propriety of subjecting this anæsthetic to the crucial test of daily practical experience. And we doubt not that if its administration be scientifically watched, and its failures and successes impartially recorded, we shall ere long accumulate sufficient evidence to determine definitely whether this new beacon of progress be an *ignis fatuus* or the veritable thrice-prayed-for banisher of pain, whose effects shall be manifested *cito, tuto, atque jucunde*.

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Drs. Canniff, of Toronto, and Beatty, of Cobourg, have been appointed Census Commissioners for Ontario.

## ONTARIO MEDICAL ASSOCIATION.

We understand that the Committee appointed in this city to confer with the members of the profession throughout the country concerning this subject have decided to call a meeting soon for the purpose of organizing a Medical Association for this Province. As far as we can learn from various sources, medical men west and north of Toronto, and east, as far as Kingston, are unanimously in favour of the scheme—in fact, the greater proportion of them have been for some time. We regret that the Ottawa Medical Society considers its establishment “inexpedient at the present time.” We understand that Dr. Grant, whose opinion is entitled to the highest respect on account of the untiring zeal and energy which he has always shown in advancing the best interests of the profession, considers the undertaking undesirable at present, but thinks that we should rather endeavour, for a few years at least, to throw all the life-blood possible into the Dominion Association. We cordially sympathize with the opinion here expressed, but at the same time feel certain that the organization of a Provincial Society in this, any, or all the provinces, will not in any way weaken the Dominion Association, but will rather tend to strengthen it.

There appears to be a certainty that the Ontario Association will be established under the most favourable auspices, and we wish it all success. We will not undertake to discuss details, but leave these for the consideration of the Society or the Committee before referred to. One question has, however, been brought forward frequently—should its meetings be held always in one place, or should they take place successively in several different cities? Much might be said on both sides of this question; but we must say, we incline to the view that it would be much better not to limit the place of meeting to one locality, nor prescribe any fixed rule for the present, but rather leave this, with other questions, to be decided by the Association after it is properly organized. The 10th of March has been mentioned as the day for the preliminary Convention.

*The Obstetrical Journal of Great Britain and Ireland* has suspended publication.

## MALPRACTICE.

At the Hamilton Winter Assizes, the case of *Tost vs. Freeman*, referred to in a previous issue, was tried and disposed of, resulting in the entry of a non-suit. We offer our hearty congratulations to Dr. Freeman upon this happy termination of a most vexatious and unrighteous prosecution. The particulars of the case are published in another column. At the conclusion of the trial, the presiding Judge, Mr. Justice Galt, gave expression to some pertinent and too oft-forgotten truths concerning the arduous nature and precarious character of professional services. For this timely recognition, in high places, of the difficulties and dangers of medical practice, we thank him in the name of a profession too obnoxious to malicious prosecution, and too little accustomed to a grateful appreciation of duty faithfully and painfully discharged.

NEW PRIVATE HOSPITAL FOR WOMEN.—We are glad to be able to inform our readers that a new hospital of this kind has been just opened in New York city, at the corner of Lexington Avenue and 52nd Street, by the world-renowned T. Gaillard Thomas and another distinguished surgeon of the New York State Woman's Hospital, Dr. Jas. B. Hunter, President N. Y. Obstetrical Society, whose mother and immediate relations are residents of this city. We hear so frequently of Canadian women resorting to the great American Metropolis for special advice and treatment that we are sure this announcement will be read with great satisfaction in all parts of the Province. We by no means encourage an exodus to Gotham while we have very excellent gynaecologists at home, but we trust that when occasion really arises, these latter will bear the existence of this new institution in mind, and direct their patients accordingly. Rooms, we suppose, can be secured by application to either of the medical officers.

See among advertisements an excellent opening for a medical man in a flourishing town; also, an assistancy wanted.



At a meeting of the Senate of Toronto University, convened for the purpose of choosing a Vice-Chancellor to fill the place of the late Chief Justice Moss, Mr. Wm. Mulock, M.A., was elected to the office. Mr. Mulock was among the first members of the Senate elected by Convocation, and since that time has always been one of the most diligent and prominent among them. He is thoroughly conversant with all University matters, and takes a keen interest in everything pertaining to her welfare. He possesses tact, energy and ability, and being a University man of the right sort, is, in our opinion, well fitted for the position.

*The American Medical Bi-Weekly* (formerly published in Louisville, Ky., and for a time suspended owing to the illness of its editor, Dr. E. S. Gaillard) has resumed publication in New York, whither the editor has removed. No. I. of Volume 12 has been received. Subscription price \$1 per annum.

In the Circuit Court at Fredericton, N.B., an action is now pending to recover \$10,000 damages for loss of eyesight. The plaintiff, who is stone blind, is one Robert Dippin; the defendant, Dr. Dow.

We are pleased to announce, but regret to take our information from a lay source (*The Globe*), that Dr. G. S. Ryerson, of this city, has been elected a member of the Ophthalmological Society of Great Britain.

Dr. Mostyn, of Almonte, has been elected President of the Agricultural Society for the North Riding of Lanark.

#### APPOINTMENTS.

Dr. F. W. Strange to be surgeon Queen's Own Battalion, vice Surgeon Major Thorburn, who retires, retaining his rank.

Drs. J. H. McCollum and G. S. Ryerson to be Surgeon and Assistant Surgeon of new 10th Royals.

Drs. McPhedran and Jehu Ogden have been appointed Surgeons to the Toronto Dispensary.

#### Obituaries.

##### CHIEF JUSTICE MOSS.

In the death of this learned and upright judge the medical profession, no less than our brethren of the bar and the public generally, finds great occasion to mourn the common loss. We therefore feel it to be at once our pleasure and our pain to recall the salient incidents of his bright career, and to record the melancholy circumstances of its too early termination. Born in Cobourg, in 1836, his early education was acquired at Upper Canada College, where the budding genius of the boy gave ample promise of that so rich fruit which ere long characterized the man, and made the giant tree, known of all, the admiration and ensample of the saplings growing up around him far and near. In graduating at the University of Toronto in 1858, he gained the remarkable distinction of a triple first (in classics, mathematics, and modern languages). Passing then into the wider sphere of active life, he soon acquired a pre-eminent position at the Equity Bar, and at the early age of forty-one became Chief Justice of Ontario and President of the Court of Appeal. The bare narrative of this career, and the recollection of the vital strain and unintermitting nervous tension necessary for its accomplishment, cannot be devoid of interest and instruction to us who are sent to preach the gospel of physiology and obedience to natural laws. When we find one of his brother judges (Mr. Justice Burton) averring that even after his accession to the Bench "the rising sun occasionally found him still engaged in examining and verifying the authorities," all wonder dies that the age of forty-three brought with it an exhausted store of reserve energy and vital resistance totally unequal to the tolerance, much less the repulsion, of any serious pathological invasion. *Cito rumpes arcum, semper si tensus habueris.*

It is, however, as one of the foremost friends of liberal and scientific education in this country that the medical profession will most deeply feel his loss. Soon after graduation he was appointed Registrar of the University of Toronto; and in this position probably acquired

a closer insight into the requirements, capabilities and defects of University education in this country than anyone else possessed. Subsequently called, some seven years ago, to fill the most important executive office of Vice-Chancellor, his past experience and extended influence soon made him the well-spring of all University reform; and, to refer only to the Faculty of Medicine, we owe him a large debt of gratitude for the new medical curriculum and all the benefits which must flow therefrom.

Some four or five years ago, the late Chief Justice passed through an attack of whooping-cough, and subsequently suffered occasionally from acute hepatic congestion. Early in 1880, epistaxis, with evidences of hyperæmia of the mucous membranes generally, occurred, followed in March by copious hæmatemesis and unmistakable evidences of cirrhosis. His strength was at this time much reduced, but subsequently improved. During a summer sojourn in Muskoka chills occurred, again followed by improvement; but in October last the hepatic symptoms recurred, accompanied this time by dropsy. Absolute abandonment of work was now insisted upon, and in order that this advice might have the weight of the highest authority he was advised to consult Prof. Alonzo Clark. From a letter addressed to the Registrar of the University (Nov. 1), tendering his resignation of the Vice-Chancellorship, we find that he was at length convinced of the necessity of rest—too long deferred! "The state of my health," he writes, "is such as to render absolute freedom from mental effort, care, and responsibility essential. Without this, the probabilities of a restoration to health are much diminished, and other remedial agents of comparatively little avail. This was the opinion of Dr. Thorburn, my regular physician; and its correctness has been amply confirmed by the distinguished New York doctors whom I have recently consulted. Indeed it is very probable that I shall be compelled to winter in some milder climate." In pursuance of this view he proceeded to Nice, where he unfortunately succumbed on the 4th ultimo.

Eminent jurist, accomplished man, and perfect gentleman; genial companion, fond father, and faithful friend; eloquent of speech, affable in demeanour, sympathetic in difficulty or distress, the chief *presidium et dulce decus* of *Alma Mater*, the pride of relatives and friends—take him for all in all, he was a man whose like, we fear, we shall not look upon again.

## Book Notices.

*Cases Treated by the Lister Method, reported to the Portland Clinical Society.* By FREDERIC H. GERRISH, M.D., Portland.

*On Heredity in Progressive Muscular Atrophy Illustrated in the Farr Family of Vermont.* By PROF. WM. OSLER, M.D., M.R.C.P. London.

*The Surgical Treatment of Cancer of the Rectum.* By CHARLES B. KELSEY, M.D. (Reprint from *American Journal Medical Science*, Oct. 1880.)

*Ninety-eighth Annual Catalogue of the Medical School (Boston) of Harvard University (1880-81) Cambridge.* Published by W. SEVER, 1880.

*Proceedings of the Louisiana State Medical Association, third meeting, New Orleans, March 31st to April 2nd, 1880.* J. S. Rivers, 74 Camp Street, New Orleans.

*Scarlatina. A Lecture delivered in the Jefferson Medical College.* By WM. B. ATKINSON, A.M., M.D. (Reprint from *Med. and Surg. Reporter*.)

*Case of Pyo-Pneumothorax Subphrenicus (Leyden).* By WM. GARDNER, M.D., Prof. Med. Jurisprudence and Hygiene, McGill University.

*Phthisis Pulmonalis, and its Treatment with Hypophosphites.* By L. DEBREMONT, M.D., Paris. New York: John Newton, Publisher, 33 Beekman St., 1880.

*Report of the Board of Health of the State of Louisiana for the year 1880.* By JOSEPH JONES, M.D., President. New Orleans: J. S. Rivers, Stationer and Printer, 74 Camp St.

*The Surgical Treatment of Intestinal Obstruction.* By W. T. BRIGGS, M.D., Prof. Surgery in University of Nashville. (Reprint from *Nashville Journal Medicine and Surgery*.)



*Soluble Compressed Pellets. A New Form of Remedies for Hypodermic Use.* By H. AUGUSTUS WILSON, M.D. Reprint from *Philadelphia Medical Times*. L. Wolff, M.D., Pharmaceutical Chemist, N. W. cor. Chestnut and 12th Streets, Philadelphia.

*Physician's Visiting List.* Lindsay & Blakiston, Philadelphia.

This well-known List appears this year as usual, with its many commendable qualities. We regret that excess of matter crowded mention of it out last month, but doubtless the majority of our readers have already secured this indispensable *vade mecum*.

*How Persons Afflicted with Bright's Disease Ought to Live.* By JOSEPH F. EDWARDS, M.D.

This is a little work in primer form, and containing some eighty odd pages of reading matter. The plan of the work indicates that the aim of the author has been, not so much to throw additional light upon the subject in hand, as to present in a readable form, some practical suggestions to those of the public who may be suffering from Bright's disease in any form. Viewed in this light, the work is entitled to be considered as fairly accomplishing the aims of the author.

*Atlas of Skin Diseases.* By LOUIS A. DUHRING, M.D. Part VIII. Philadelphia: J. B. Lippincott & Co.

Such high encomiums have, on all hands, greeted the appearance of successive numbers of these plates that the fullest meed of praise which can be accorded to Part VIII. is to say that it is worthy to succeed its predecessors in the series. The affections figured with much faithfulness and skill are Erythema Multiforme (Papulosum), Psoriasis, Syphiloderma (Tuberculosum), and Tinea Tricophytina (Circinata et Tonsurans). We trust that no one who can afford to buy the work will be content to remain without such a valuable addition to his library, and such an efficient aid to the recognition of the too often neglected diseases of the skin. The letterpress is a model of conciseness, but all too brief.

*Diagnosis and Treatment of Ear Diseases.* By ALBERT H. BUCK, M.D. New York: William Wood & Co. 1880.

This work forms one of Wood's Library, and will therefore serve to impress a large circle of practitioners, who otherwise might not be reached, with the fact that diseases of the ear always merit attention and very often demand treatment. The statement that "a localized meningitis may be assumed to exist in every severe case of acute purulent inflammation of the middle ear," conveys a moral which is too seldom heeded. The author's "aim has been to present, in text-book form, a picture of diseases of the ear as they have appeared in private and hospital practice;" and he has admirably succeeded. His book abounds in practical lessons based on original research and a large experience; and the modesty, candour, and conservatism of the author enhance the value of his teachings.

*Treatise on Therapeutics.* By A. TROUSSEAU and H. PIDOUX. Translated by D. F. LINCOLN, M.D. Ninth Edition. Vols. II. and III. New York: Wm. Wood & Co.

The opening article of Vol. II. is an exposition of the great question of antiphlogistic treatment. Blood-letting is now on the wane, but the arguments of its partisans are put fairly, though Bouillaud's "intemperate and ambitious antiphlogistic treatment" are spoken of, and Lordat is quoted as saying—"Bleeding to pallor is the knout of therapeutists. It puts those whom it does not kill in a state where for some time they cannot exhibit symptoms." Evacuants are divided into emetics and cathartics, and Ipecac. and Tartar Emetic receive considerable notice. Strychnia and Ergot of Rye are the selected examples of excito-motors. A chapter on Narcotics concludes this volume.

Vol. III. begins with a chapter on Anæsthetics; passes on to Antispasmodics, and Neurasthenic Tonics, under which he discusses cinchona and the treatment of intermittents. The power of quinine in lowering the temperature does not appear to be noticed; though later on, this power is ascribed to digitalis, through its action on the pulse. Under the head of Excitants he places Diuretics, and discusses at some length the opposing doctrines of Brown

and Broussais. Chapters on Sedatives and Anthelmintics close the volume.

The treatise abounds in details of treatment, and is interspersed with keen clinical observations, while the free and flowing style render it easy of perusal. Although, in comparison with Ringer, Fothergill, &c., some of the ideas may appear old-fashioned if not obsolete, we are pleased that the work is placed within the reach of the profession.

*The Venereal Diseases, including Stricture of the Male Urethra.* By E. L. KEYES, A.M., M.D. New York: Wm. Wood & Co., 27 Great Jones' Street. 1880.

It is not our intention to review this book, since the space at our disposal would be quite inadequate to do so justly. We do not hesitate to say, however, that we know of no book of its kind that we like so well; none that contains a similar amount of thorough, practical information in the same space. Written by a master of the subject, as well as of his mother tongue, it presents in a clear, forcible, judicial, fluent, and pleasant style, totally devoid of dogmatism, the well-digested pabulum of a wide practical experience and thorough acquaintance with an almost limitless range of literature. No better man could have been selected to perform the task; none could have accomplished it more satisfactorily. Evidences of clerical haste alone mar the text. Part I. treats of Chancroid which is disposed of in four chapters. Part II. deals with Syphilis, to which some fifteen chapters are devoted, wherein the subject is philosophically considered in all its aspects. It will be remembered that our author is the originator of the "tonic treatment of syphilis." We are pleased to find that he is thoroughly in accord with the best French authorities as to the necessary duration of treatment, and selects three years as an appropriate term. We do not think that the necessity for this long-protracted medication is as yet sufficiently recognized by the profession in general. Part III. disposes of Gonorrhœa (in both sexes) and its complications, in seven chapters, with equal intelligence, lucidity and skill. Surely we cannot commend the book more highly to our readers. We trust all will read it, and we know of none in this Dominion who will not rise from its perusal a better practitioner—a wiser man. The one drawback about it is its publication only in a series—Wood's Library for 1880.

*How to Use the Forceps; with an Introductory Account of the Female Pelvis and of the Mechanism of Delivery.* By HENRY G. LANDIS, A.M., M.D., Prof. of Obstetrics and Diseases of Women and Children in Starling Medical College. Illustrated. New York: E. B. Treat, publisher, 757 Broadway. 1880.

This little 12mo. volume of 168 pages is really a very valuable addition to obstetric literature and practice, and very cogently inculcates certain by no means universally accepted views, which we believe to be pre-eminently sound. The work is divided into two parts: the former treating of the Mechanism of Labour, the latter of the Forceps. The account of the anatomy of the pelvis is remarkable for its lucidity (illustrated by diagrams), conciseness and intelligence; and, to compare the less labour with the greater, exhibits as elegant an illustration of the teleological argument as did Charles Bell's great essay on the Human Hand. In this chapter, two errors sanctioned by high authority, and perpetuated by slavish imitation, have been corrected. The first is Hodge's definition of the plane of the superior strait, which our author shows to be absurd, since "as a matter of fact the circumference of the inlet bounds two distinct planes whose inclination to one another is about at an angle of 150°. The second error confuted is the supposition that the uterus, during labour, is placed directly in the median line. In the section on the propelling forces of labour, we are glad to find our author a disciple of Poppel and Matthews Duncan. In the description of the child's head we note an error, on page 40, where "bregma" is given as a synonym of the posterior, instead of the anterior, fontanelle. The Mechanism of Delivery in the four vertical and four facial presentations is then admirably described, and the inaccuracy of Hodge's description fully demonstrated.

The forceps are then described, and our author is a warm advocate of the Davis forceps in all respects—blades, lock and handles. He prefers a wide blade with a large fenestrum (or fenestra, as we would prefer to write it); and approves of the secondary head curve (from above downwards) of the Davis instrument as diminishing the liability to slip. A considerable pelvic curve is regarded as a desideratum.



In the matter of locks, preference is given, and with apparent justness, to what is known as the flat-button lock—another feature of the Davis forceps. In the application of the forceps the position on the back is recommended, and, we think, with every show of reason. The application to the sides of the child's head is cogently urged, and very excellent directions accompany this injunction. He condemns the passage of the instrument in the *pelvic curve in toto*, and crosses swords at once with Baudelocque, Levret, Cazeaux and Schroeder, Leishman, Barnes and Fauntleroy. While we cannot but admit the force of his arguments, yet our own experience inclines us to believe that the procedure which he deprecates is oftentimes the easier and more practicable one; and, moreover, in this benighted country, where malpractice suits are not yet unknown, it will perhaps continue to be "enough to satisfy the ambition of a private man" to act upon the principle, "*Malo errare cum Platone quam cum aliis sentire verum*," as being at once both prudent, and dictated by "the first law of nature." In speaking of traction, the author describes a method of effecting this when the forceps are applied at the inlet, which we ourselves have frequently practised, as have others to whom we have spoken about it. For a description of it, want of space compels us to refer our readers to the book itself. With reference to the amount of force to be employed, we are persuaded that the author is right in stating that *great* force can never be required, and, moreover, "cannot be applied in the right direction." Pendulum leverage is discarded as useless and injurious, and we think rightly so in view of Smith's able demonstration of its effects; and our author has little to say in favour of "rotation" by means of the forceps, an instrument capable of little good and much evil in this regard.

We regret that want of space prevents us from discussing many interesting and instructive points considered in the text; but we are persuaded that we cannot do our readers a greater service than advise each of them to buy and criticize this little volume for himself. We know of no way in which a dollar and a half of money and two hours and a half of time could be more profitably invested.

*Lessons in Gynecology.* By WM. GOODELL, A.M., M.D., Professor of Clinical Gynecology in the University of Pennsylvania, etc. Second Edition. Philadelphia: D. G. Brinton.

Dr. Goodell has been known for some time as one of the best clinical teachers on the Continent, and the publication of his "Lessons" was looked for with much interest. So popular was his work that the first edition, although a large one, was exhausted in a few months. We have now before us the second edition, which we have perused with much interest. The author aims at no great elegance of diction, and yet the style is attractive. Any one, who commences to read it, is not apt to be satisfied until he has reached the last page. In this edition the whole matter has been revised, and four new lessons added, together with twelve new illustrations.

After a description of instruments and modes of examination, he treats of affections of urethra, bladder, and vulva. We endorse everything he says in the main, but would suggest caution in the use of "large doses of quina" in cystitis, as, according to Milner Fothergill, and Stillé, this medicine is apt to produce irritability in a healthy bladder, especially in elderly people. It has appeared to us at times to produce this effect in people who could hardly be called elderly. Lessons ix. and x., on laceration of female perineum, with treatment, are especially good, although, we think, he is rather hard on the forceps. A word of caution in the use of this valuable instrument may, however, become necessary in this fast age, when the tendency is to rush through everything at railroad speed.

In treating acute and chronic metritis, and endo-metritis, the author uses the more ordinary terms, and does not adopt Thomas's term, areolar hyperplasia for chronic metritis. He makes no effort to draw those nice distinctions between inflammations of the neck and body of uterus respectively which are often more perplexing than useful. His account of the various mal-positions of the uterus is clear, and his description of different kinds of pessaries, and mode of using them, is in the main correct, though, we think, he rather

favours Hodge, or Albert Smith's modification of it, at the expense of the elastic spiral ring, which is, in our opinion, one of the best and safest pessaries now made. With reference to the intra-uterine stem-pessary, our author's opinions appear to have undergone various changes; but now he is convinced that it is very useful in many cases both of ante flexion and retroflexion. Again we venture to recommend caution, as we entertain a strong prejudice against these rather innocent looking little machines, which are capable, however, of exciting very serious mischief, especially when used by any but the most skilled hands.

The chapters on lacerations of the cervix, the significance of which was first pointed out by Emmet, are all that could be desired. For the treatment of vegetations of the endometrium, which he divides into three kinds, he depends mostly on the curette, generally using Thomas's blunt, but Sim's sharp when necessary. He discusses fully the nature and treatment of benign and malignant tumours of uterus and ovaries, including the comparatively new operation for the extirpation of the latter.

One of the best chapters in the book is that on "nerve-tire, and womb-ills; or, the relation of the nerves to diseases of the womb." This "lesson" shows very clearly that many of the disorders of the uterus, which accompany neurasthenia or hysteria, are merely local manifestations of the general neurosis. Nothing more useful could be written for some of those enthusiastic, but half-educated specialists, who at once rush to the womb to search for the causes of all the aches and pains which can be found between the scalp and the toe nails. The last chapter, on "the sexual relations as causes of uterine disorders," including conjugal onanism and kindred sins, has excited much attention and some unfavourable comment. After all, these evils exist to an alarming extent, and every one knows the facts; why then should physicians close their eyes, and ignore them entirely, through any childish ideas of delicacy?

Throughout the whole work there runs a vein of sound common sense and practical wisdom. As a book of the kind—and the kind is a good one for the general practitioner—we know of none better. Get it as soon as possible, and we feel sure you will read it.

## Meetings of Medical Societies.

### HURON MEDICAL ASSOCIATION.

The regular annual meeting of the Huron Medical Association was held in Clinton on Tuesday, January 11th; Dr. Sloan, vice-president, in the chair. The following members were present: Drs. Sloan, Hyndman, Worthington, Holmes, Williams, Campbell, Young, Hurlburt and Stewart.

The following were elected officers for the ensuing year: Dr. Sloan, of Blyth, President; Dr. Holmes, of Brussels, Vice-President; Dr. Stewart, of Brucefield, Secretary.

Dr. Worthington exhibited a man, aged 20, who eight years ago received a depressed fracture of the skull. The fracture involved the lower and anterior part of the right parietal bone. There was loss of consciousness and complete paralysis of the left arm and leg.

The patient regained consciousness in about seven days, but the paralysis of the extremities has persisted. Half an ounce of brain matter was lost. At present there is to be detected loss of bone in a region 2x2in., extending in an antero-posterior direction from the posterior border of the coronal suture to an imaginary line drawn from the squamous suture vertically upwards through the parietal eminence; and in a vertical direction from the upper fourth of the squamosa-temporal area to a space midway between the coronal suture and the most prominent part of the parietal eminence. This region is the seat of pulsation. The left arm is perfectly powerless, cold and atrophied. The left leg is smaller and shorter than its fellow of the opposite side, and there is considerable loss of motion in it. The tendon reflex is exaggerated. Both the left extremities have a considerable degree of "late rigidity."

The patient is not nearly so intelligent as he was previous to the accident. His memory is considerably affected, but there is no loss of speech. There is a slight divergent squint of the right eye, but with this exception the functions of all the cranial nerves are normally performed.

Dr. Sloan, of Blyth, showed a boy, aged 17, who received seven years ago a kick from a



horse, which caused a depressed fracture of the posterior part of the right parietal bone. This was followed by stupor and dilatation of the left pupil. At no time was there any absolute loss of consciousness. The depressed bone was removed. Two tablespoonfuls of brain matter came away. He made a good recovery.

The following is his present state: There is complete loss of bone in a region which is normally occupied by the posterior and inferior part of the right parietal bone. This region is the seat of pulsation.

He is as intelligent as he was previous to the accident. Functions of all the cranial nerves normal. There is no paralysis of motion or sensation. The dilatation of the pupil which was present at first disappeared in a week, and at the present time there is to be detected no difference in the size of the pupils.

[These two cases are, exclusive of their great surgical interest, of great importance from the fact of their being a contribution to the literature of cerebral localization. Two boys about the same age receive injuries by which they both lose about two square inches of skull on the right side, and nearly in the same situation, and both lose about the same quantity of brain matter. The result in one case is complete paralysis of the left arm, complete paralysis of the left leg, and greatly diminished intelligence. The result in the other case is complete retention of intelligence, sensation, motion, and the special senses. In the former case (Dr. Worthington's), the loss of brain substance has taken place from the regions corresponding to the lower antero-parietal area and the lower part of the upper antero-parietal area. The convolutions that correspond to these areas are the ascending frontal and parietal and the posterior part of the three frontals; and as the former are the seat of motion for the opposite extremities, and the latter the seat of intelligence, the explanation of the effects of the injury are evident.

In the second case (Dr. Sloan's), the loss of brain has occurred principally in the lower postero-parietal area, only a small portion of the part corresponding to the posterior part of the lower antero-parietal area being involved. These regions correspond to the upper temporo-

sphenoidal convolution and the gyrus supra-marginalis, destruction of which has no effect on either intelligence or motion. Irritation of the superior temporo-sphenoidal convolution causes dilatation of the pupil of the opposite eye and a turning of the head and eyes to the opposite side. The dilatation of the opposite pupil was present for a period of a week in this case, but there is no record whether there was any deviation of the eyes or not. It is not known whether the patient was able to see with his left eye or not.—Note by Secretary.]

Dr. Campbell, of Seaforth, showed a woman, aged 58, affected with paralysis agitans of the right extremities. Last August she felt her right hand becoming weak, and two months afterwards the thumb and forefinger of the same hand commenced to tremble. The tremor then gradually extended to the whole of the right side, and she can only prevent it by grasping firmly some object. At first the tremor ceased during sleep, but it is now continuous except when she puts the muscles into use.

On two occasions lately she has had attacks apparently of an apoplectiform character. During one of these seizures there was loss of speech and difficulty in swallowing. Both sensation and motion are depressed in the right extremities; the former markedly so, the latter but slightly. Patient walks with a shuffling gait, and is inclined to run forwards.

Drs. Stewart and Hurlburt showed a case of exophthalmic goitre in a woman aged 32. The first symptoms made their appearance very suddenly nine months ago. At present there is marked enlargement of the thyroid, protrusion of the eyeballs, and palpitation of the heart. She has been taking 3iss. of the Fl. Ext. Ergot daily for three weeks, but as yet with no results.

Dr. Worthington showed a boy, aged 14, who is wearing a "Wyeth's Extension Jacket" for disease of the fourth and fifth dorsal vertebrae.

Dr. Hyndman showed a case of necrosis of the lower jaw.

It is proposed to call a meeting of the Profession in the city shortly, to arrange a general meeting anent the formation of the Ontario Medical Association.

## TORONTO MEDICAL SOCIETY.

*December 16th, 1880.*—The Society met at 8 p.m., the Vice-President, Dr. George Wright, in the chair. The minutes of the previous meeting were read and confirmed.

Dr. Canniff asked the indulgence of the Society while he exhibited a patient upon whom he had operated, excising the elbow joint, for extensive articular disease. The biceps tendon being partly destroyed, rendered the restoration of motion imperfect. Motion was now very fair.

Dr. Bertram Spencer was nominated to the membership of the Society.

Drs. T. S. Covernton and J. Lesslie were duly elected members of the Society, and Dr. R. Lesslie a corresponding member.

Dr. Cameron exhibited some specimens from a case of phlegmonous enteritis with volvulus; the small intestine was distended to twice or three times the size of the large intestine. The mesenteric glands were enlarged.

Dr. Geo. Wright exhibited a fœtus and appendages of apparently four months. He also read a paper upon malignant disease (will be published).

Dr. Graham related two cases of malignant disease, in which the early symptoms were not distinctive, and where the cachexy set in late. One case simulated renal calculus, and had been under observation for  $7\frac{1}{2}$  years. In the diagnosis he remarked that in renal calculus you had the pain, &c., for a long while without emaciation and failure of the health, but in cancer these showed themselves comparatively early.

Dr. Oldright considered cancer as a local manifestation of a constitutional taint, this lying dormant until called into action by some local stimulus. He disagreed with the reader of the paper in his view of the use of the knife. He thought the difficulty was in not operating soon enough.

Dr. Rosebrugh spoke in favour of early removal, relating cases in support of his opinion, and advised a healthy zone of tissue to be removed with the diseased mass, and the wound to be raked with the electric harrow.

Other members also took part in the discussion.

Dr. Reeve then exhibited a burr or drill which he used for boring into the mastoid cells, and said that in cases where there was persistent pain over the mastoid, simply boring into the cells often relieved the pain, even when no pus was found.

Dr. Geo. Wright gave the details of the case from which the fœtus had come which he had exhibited earlier in the evening. Mrs. V. menstruated last while nursing on the 15th May; she believed herself pregnant; in October she began losing again; and on Dec. 3, after a long walk, gave birth to the fœtus, which was dead; it was apparently only at the end of the fourth month; there was no offensive smell. Dr. Oldright mentioned a case of dislocation of the head of the fibula backwards. (Will be published.)

After some discussion, the Society resolved to adjourn until the second Thursday in January, 1881.

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SUPRAPUBIC LUXATION OF FEMUR.—Prof. Wm. Stokes, of Dublin, records (*British Medical Journal*) a case of iliopubic luxation of femur, in which the head of the bone lay above the os pubis and within the pelvis. This could only be reduced by flexing the leg on the thigh, passing the left arm beneath the knee and using the leg as a lever, lifting the head of the bone from the pelvis. Abduction and rotation inwards then brought the head into the thyroid foramen, whence rotation outwards carried it into the acetabulum.

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## Births, Marriages, and Deaths.

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### BIRTH.

At "St. Leonard's," Peterboro', the wife of Dr. H. C. Burritt, of a daughter.

### MARRIAGES.

On the 12th inst., at All Saints' church, Toronto, by the Rev. Arthur Baldwin, Christopher Cuthbert Baines, to Mary Louise Covernton, youngest daughter of Dr. Covernton, Toronto.

On Dec. 30th, at the Manse, Ancaster, by Rev. J. H. Ratcliffe, brother-in-law of the bride, assisted by Rev. Prof. Gregg, D.D., and Rev. J. M. King, M.A., Toronto, Alexander McPhedran, M.D., to Jeanie, youngest daughter of Hugh R. Fletcher, Esq., both of Toronto.



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THE

# Canadian Journal of Medical Science.

A MONTHLY JOURNAL OF MEDICAL SCIENCE, CRITICISM, AND NEWS.

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TORONTO, MARCH, 1881.

## Original Communications.

### JEFFERSON MEDICAL COLLEGE HOSPITAL, PHILADELPHIA.

CLINIC OF S. D. GROSS, M.D., PROF. OF SURGERY.

[Reported for the CANADIAN JOURNAL OF MEDICAL  
SCIENCE by JOHN H. KOONS.]

[We are indebted to the kindness of Dr. J. B. Roberts, Lecturer on Anatomy and on Practical Surgery in the Philadelphia School of Anatomy, for the following reports by one of his students.]

**AMPUTATION OF THE LEG, FOR TRAUMATIC GANGRENE OF THE FOOT.**—This man, aged 45 years, was injured by a car sometime previous to his admission, and you can readily diagnose, by the condition of his foot and leg, the pathological process which is taking place. The parts have mortified, the line of demarcation has formed, and the swelling, pain, and concomitant inflammation have abated. There is no swelling in the limb above the ankle joint, but the upper surface of the foot is covered by a black slough, separated by a distinct line of demarcation from the healthy parts. Gangrene may be either traumatic or idiopathic. In this instance, where the condition is due to local injury, the gangrene is said to be traumatic; but when no injury has occurred and the mortification supervenes from some inherent constitutional cause, the term idiopathic is employed as descriptive of the causation. The proper course to be pursued in cases of gangrene is, as a rule, to wait for the line of demarcation before operating. In traumatic gangrene where the mortification is fast spreading, we sometimes find it necessary to amputate at

once in order to save life, but generally we wait for the line of demarcation. The proper time to operate, unless contra-indicated, is after the line of demarcation has fully established itself. I purpose amputating this leg a short distance above the line which shows the point at which the mortification is arrested; and I shall do it by the circular method, which I usually prefer in this locality. We apply the rubber bandage, by which the blood is driven out of the limb; and then the circulation is cut off or prevented from returning by the elastic cord firmly fastened around the thigh; the rubber bandage is then removed, and the operation rendered a bloodless one.

The practice of all surgeons is to save as much blood as possible during an operation, since hemorrhage is a serious complication and endangers prompt recovery. I shall make a circular incision above the line of demarcation, and dissect up the skin about two inches. I find that the previous inflammation has so matted the parts together that it is difficult for me to dissect rapidly. I now make a vertical incision in the circular flap, in order to turn it back, divide the tissues down to the bones, and pass a knife between the tibia and fibula to cut through the interosseous membrane. The parts are drawn out of the way by means of the three-tailed muslin retractor, while I saw off the bones. I remove this projecting point, made by the sharp crest of the tibia, which would interfere, perhaps, with rapid union of the flap, and might cause ulceration over its sharp apex.

After tying the anterior and posterior tibial arteries, the parts are now washed with hot water, which you see stops the capillary bleed-

ing better than cold water, because it coagulates the albuminous portion of the blood. In tying the arteries I have been careful not to include the nerves. Always use strong ligatures and tie firmly. The nerves and tendons must be retrenched, so that they may not be compressed and implicated in the cicatricial contraction of the stump. Here you see there is an abundance of tissue left to cover in the bone.

We shall not close the wound for four or five hours; by that time the parts will be covered with plasma or lymph, making a glazing as it were. Then it will be proper to draw the parts together at several points by the interrupted suture. I do not believe in closing up wounds immediately after amputation. If I were to close up this wound now, it might bleed between the surfaces, and this blood would putrefy. The vessels and absorbents taking up the decomposing and septic material might give rise to pyæmia and death. The man will be given half a grain of morphia hypodermically, and will be treated on general antiphlogistic principles, so as to keep his system supported by plenty of fresh air, good diet, and tonics. Gangrene occurs, as a rule, in asthenic cases, and calls for that form of antiphlogistic which may be styled corroborant.

\*   \*   \*   \*   \*

After the operation, the patient was treated with large doses of quinine and whisky; and although there was some sloughing of the flap, he is now, about two weeks since the amputation, in pretty fair condition. The sloughs have separated and the wound is healing by the granulating process.

**LITHOTOMY COMPLICATED BY VESICO-RECTAL FISTULA, DUE TO A PREVIOUS OPERATION.**—The next case is that of a man whom I had before you last Saturday. I explained to you then the nature of the case, and told you that he had had an operation for stone performed in the country, seventeen months ago, and that the operation lasted for two hours.

The patient tells us the stone was not all removed, but this is hard to decide; however, whether or not the stone was all removed at that time, we are quite sure there is one now within the bladder, of considerable bulk. He has the

rational symptoms of stone, such as pain, tenesmus, and frequent desire to urinate; and the sound introduced into the bladder through the urethra gives the characteristic percussion sound when it strikes the calculus.

On examination, it is found that the perineal wound has never entirely closed, and the urine has been passing out through the perineum ever since the operation. I told you there was also a wound in the lower bowel of considerable size. Hence, the unfortunate patient has urine escaping by the rectum, the perineal wound, and by the penis.

We will attempt to close these openings by an operation, after removing the stone now in the bladder. In regard to operation for stone in the bladder, I may say to you that great care should be taken not to wound the rectum; for although it may not interfere seriously with recovery, yet the chances are that it will cause trouble, by leaving a permanent communication between the bladder and rectum. I never in my life had the misfortune to perforate the rectum in an operation of this kind, and I regard the occurrence as a great evil, though by some it is not considered as such.

If the urine is allowed to pass into the rectum, great pain and irritation is the result; and if the fecal matter is allowed to pass into the bladder, even greater injury may follow. A long time is required to heal such an opening, if indeed it can be healed at all; and in any event the surgeon should guard against such an occurrence.

When about to perform lithotomy you should see that your patient is properly prepared before you attempt to operate. This man has had his bowels well moved, as should always be done; and it is often well to give your patient a little whisky or brandy before the operation. Your instruments should be spread out on the table in the order needed, and carefully covered with a towel, so that the patient may not see them, as every precaution must be used to prevent shock. The parts should be shaved previous to the operation; and when everything is prepared, the staff is inserted and held in the proper manner, with its curved portion firmly supported against the arch of the pubes. There will probably



be some bleeding from the hæmorrhoidal arteries and veins, but this I imagine we will be able to check easily. I make my incision in the usual manner, in front of and to the left of the anus, through the perineal fistula left by the former operation; and now I find the groove in the staff with my left finger and, running the knife along it, divide the urethra and prostate, and open the bladder. The stone is large, and, as the edges of the bladder embarrass my proceeding, I am obliged to divide the parts still further. Now, as I have removed the stone in several pieces, we wash out the bladder with a syringe, in order to remove any blood-clots or calculous matter that may remain behind.

It is always well to have some experienced man to examine the case after the operation, lest you be assailed for malpractice. This man will be removed to the ward, where a bed, especially for this purpose, is prepared in the following manner:—Upon the mattress is spread a sheet in the usual way, and on this is placed a soft oilcloth, over which again is placed what is known as the draw-sheet, consisting of an ordinary sheet folded several times and placed under the buttocks. This helps to keep off the pressure as well as receive the discharges, and can be changed several times a day without disturbing the patient. The bowels should be locked up for three or four days by a full anodyne, and in this instance the patient will be given half a grain of morphia as soon as he has sufficiently recovered from the effects of the anæsthetic. His diet will be of the most concentrated character. The perineal wound will probably heal in a few days, and it may possibly be requisite and proper at some future time to attempt to close the old rectal fistula.

\* \* \* \* \*

Now, two weeks after the operation, the man is in good condition. The urine still passes from the wound of operation, which is contracting, and, of course, from the rectum, as the fistula was not closed by any attempt at plastic operation. He has less frequent desire to urinate, and says less urine passes from the rectum than formerly. His condition has been greatly improved by the removal of the stone.

## BRAIN LESIONS AND FUNCTIONAL RESULTS.

BY DANIEL CLARK, M.D., TORONTO.

(Read before the Canada Medical Association, at Ottawa, Sept. 1st, 1880.)

(Continued from page 40.)

Private Samuel D. Solomon was wounded at Bull Run, Aug. 27th, 1862, by a carbine ball, which struck at a point two inches behind the tip of the left ear. The missile entered the brain to the extent of two inches and was not extracted. When struck he fell to the ground, but retained his consciousness. Healthy supuration followed, and a fragment of bone was discharged from the wound. He suffered from headache, and also from acute darting pains across the base of the brain, from the right temple to the scar of the wound. No paralysis existed, and the functions of the body were generally well performed. He afterwards served in a Washington Hospital in the capacity of nurse, and was discharged the service in the subsequent year, with no record of mental unsoundness or functional disability.

Corporal Wood, wounded at the battle of Winchester by a conoidal ball, which fractured the occipital bone and entered the brain. This was Sept. 19th, 1864. He was examined by a Confederate Board, on March 24th, 1865, whose members recommended that he might be employed at some post where the duties were not laborious, showing his mental faculties could not have been impaired to an appreciable degree. No functional results were seen.

Private Sheridan was wounded at the siege of Vicksburg by a canister shot. The missile entered the left parietal bone, immediately posterior to the coronal and three inches from the sagittal suture, passed horizontally inward, a distance of two and a-half inches and lodged. The ball could not be extracted. He suffered but little inconvenience. The wound suppurated freely, sometimes bled, and small fragments of bone escaped. Six months after, he was placed to work on the levee, and experienced no trouble, except on approach of a storm, when he had a dull pain and sensation of weight. In eight months after the wound was received he returned to duty.

Lieut. Lilycrantz, wounded at Fort Pulaski. The ball perforated the os frontis, over the right superciliary ridge. When first seen after the injury he was vomiting freely, and about a fluid ounce of brain matter had exuded from the wound. A probe, five inches long, glided easily, by its own weight, its full length directly backwards through the wound without coming in contact with the ball. For ten days the patient showed a tendency to sleep, but was easily aroused and would converse freely, constantly wandering, however, from the topic of conversation. He could, at this time, neither taste nor smell, and his hearing and sight were much impaired. He recovered his mental faculties to such an extent as to be employed in Government service at Washington, and died five years afterwards. During this time he articulated distinctly; had no paralysis, but had occasionally slight attacks of epilepsy, but they were becoming slighter as time wore on.

I have culled these cases out of 559 persons who received penetrating or perforating fractures of the skull. These 559 were selected out of 4,350 cases of gunshot wounds of the cranium and its contents. Of that large number many were afflicted with functional and mental disturbance, but in no two cases of similarly injured were there like results.

Dr. Van Peyma gives a record of a singular case in the *Buffalo Medical and Surgical Journal*, December, 1873:—

A man, aged 50, was found comatose and brought to the Buffalo General Hospital. He subsequently was sufficiently roused to give his name and age. He died six days after admission. On *post mortem* examination, the meninges on the right side were found considerably congested. On removing the brain a collection of pus was found at its base, extending from the medulla oblongata forwards. The lateral ventricles were also found filled with a purulent collection. At this moment, as the incisions were being extended, something was heard to fall on the tray on which the brain was lying. To our utter amazement this was found to be a bullet. The ball, which was of small size and considerably flattened, had been liberated by the knife. The con-

viction was forced upon us (says the surgeon) that the external opening, through which the ball had passed, had been overlooked during the life of the patient, and that this was the real cause of death; but our astonishment was increased when, after a careful examination of the surface, no opening could be found. As a last resort, the cranium was examined from the interior; and on the anterior surface, above and a little to the right of the left orbit, was found a fracture of the frontal bone, the internal table of which was extensively fissured. With this as a guide, we again made search for the external aperture, and again failed in finding an opening, but finding a discolouration of the skin over the seat of the fracture, of a lead colour, circular in shape, and the size of a ball. There was not the least sign of a wound or the slightest scar. The wound, which must have existed, had healed perfectly, and left nothing but this leaden discolouration to show its former presence. The course of the ball through the brain could still be traced by a probe to the place where it had lodged, near the anterior surface of the medulla. The opening in the bone was filled in with a gelatinous material through which tenaculum passed readily. There was no previous history of the case, but it was evident that the wound had been inflicted a considerable time before death; and seeing the patient had not found refuge in a poor-house, hospital, or asylum, the inference is fair that the intellect had not been much impaired, if any, up to the fatal attack. I am the more ready to think so, from the immunity enjoyed by patients similarly afflicted. There could not have been serious functional results as he had been able to look after himself.

A somewhat analagous case is recorded by Dr. Prewitt, of the City Hospital, St. Louis (*St. Louis Medical and Surgical Journal*):—A man, aged 32, shot himself with a pistol. The ball entered the forehead about an inch and a half above the supra-orbital ridge. He recovered in a little over a month, and *without marked impairment of intellect*. He died eleven months afterwards from erysipelas. No functional impairment is mentioned.

Ast.-Surgeon P. F. Harvey, U.S.A., reports



the following case (*vide American Journal of the Medical Sciences*, July, 1879): It is that of an Indian Agency physician who received a Winchester rifle-ball three inches and a quarter above and one inch behind the right external auditory meatus. The missile took a transverse direction across both hemispheres toward the left supra-orbital convolution. A grooved director was easily passed in this track, a distance of five inches, without, however, reaching the ball. The patient did not lose consciousness on being wounded, and complained only of "seeing stars" and of some confusion of ideas. He recovered so rapidly that, after five days of convalescence, he took a journey of 90 miles, in December, in an open buggy, alighting several times to make his way on foot through deep snow-drifts. At the end of this exertion, however, two convulsions occurred, and the wound in the head re-opened. In a short time complete convalescence ensued. Six months after the wounding the patient travelled across the plains to his home in Indianapolis, and on his arrival reported himself in excellent condition.

Dr. Hopwood, of Ashton-under-Lyne District Infirmary, England, gives, in the *London Lancet*, an account of a case under his care last summer. A male patient, aged 28, was engaged in removing the centre support of the arch of a brick-kiln, and before he could get out of the way the arch fell, burying him and several others in the ruins. All the bones of the face were crushed in; and among other injuries the coronoid process of the lower jaw was broken off, and there was a depressed fracture of the temporal bone just above the zygoma, from which the brain protruded to about the size of a strawberry. The coronoid process of the lower jaw and the zygoma were removed, the protruding brain matter was shaved off and the temporal bone elevated. Temperature at this time was 99° Fah., pulse 62. The patient was perfectly sensible when brought to the Infirmary, and thought he was only slightly hurt. There was no shock, nor had there been any. The pupils were perfectly regular, and there was no paralysis. There was no mental disturbance at any time, and ten days after the injury he said "he felt as

well as ever he did in his life." The injury was inflicted on 30th July, 1879, and on Oct. 14th following, he was quite well and working regularly.

John MacEvoy, of Paterson, N.Y., a lad of 15 years of age, was gathering sawdust in a sawmill last December. He had crawled under a circular saw going at a speed of 2,500 revolutions a minute. The saw was twelve inches in diameter, and nine inches of this was under the table. Becoming startled by a noise, the boy suddenly raised his head, bringing it in contact with the saw. The saw had made a clean sweep from the upper part of the frontal bone to the right side of the nose. The right upper eyelid was completely severed, but the eyeball was untouched. The cut was three-sixteenths of an inch wide, and the edges of the wound were smooth. The boy was able afterwards to walk, and told how the accident had happened. He appealed to the physician to save his life, saying that he did not want to die. During the dressing of the wound the boy straightened up several times, and the physicians were obliged to tell him repeatedly to lie still. He obeyed as readily as a well person would and understood what was required of him. He took in his hand a glass of whiskey which was given him, which he drank without assistance. The accident happened on Monday; and during the week his intellect remained unimpaired until Saturday, when convulsions set in and he died. No *post mortem* was allowed by the parents, so the exact extent of the injury could not be ascertained. Taking the extent of the surface wound as a basis of conjecture, or, speaking mathematically, as the segment of a circle, the deepest serrated rim of the saw must have entered at least two inches into the skull and brain together. The cut was as clean as if done with a sabre, and was no doubt done almost as rapidly. Towards the end, paralysis set in; but, strange to say, the medical men differed as to which side or limbs were paralyzed. No functional impairment was seen until the boy was dying.

Dr. Quin, the Chief Surgeon of the hospital where the boy lay, gives another case which came under his notice years before. There

was a boy named Murphy who fell out of a window of considerable height upon the curb-stone in the street. He struck it with his forehead. When he was picked up, more than a teaspoonful of brain matter oozed out of his head. He got well, physically and mentally, and lived to be 22 years old, although he was only 5 years old at the time of the accident.

Of another case the doctor says: "There is Joe Murphy. You may see him almost any day walking round the streets here. He is lame and drags one foot a little. One day, in 1864, I was going along the street, when some people came running after me. I went into a basement and found Joe Murphy had been shot in the right eye two minutes before with a bullet 38-900 calibre. I probed the wound and found the bullet flattened against the back of his skull. It is there yet; but Joe got well, and *his mental faculties are unimpaired*. I've been intending to make a *post mortem* examination of his head, but I begin to think the old man will outlive me."

In the *Canada Lancet* of April, 1872, Dr. T. R. Dupuis, of Kingston, Ont., states the case of a boy who had been injured by a fall from a horse while going at a rapid rate. The lesion was a compound fracture at the middle of the superior portion of the left parietal bone, with considerable laceration of the brain. The broken piece of bone was nearly an inch and three-quarters long, three-quarters of an inch broad at one end, and three-eighths of an inch at the other. One edge of this piece was driven down into the brain in such a manner that its surfaces occupied a position perpendicular to their original situation, while the other edge remained *in situ*, being still attached to the solid bone by the *dura mater*, which formed a sort of hinge upon which the fragment turned. The history of the case states that the injury had been inflicted by the sharp edge of a stone. After exploring the wound with the points of the fingers—which passed in readily to the depth of half an inch or more—the fragments were extracted by means of forceps. Nearly a tablespoonful of brain substance was lost. At first, the patient was comatose.

This state continued for two days. At the end of the second day he had lucid intervals. On the third day consciousness began to return, and with it voluntary motion. At this time the wound was discharging disintegrated brain matter, mixed with grumous blood and pus. Thirteen days after the accident the delirium was gone, but the mind was fickle and temper irritable and capricious. Without entering into the whole history of the case as given, it may be said, the doctor adds, that a month after this lesion had taken place all effects of this severe injury had passed away, except a slight puffy appearance about the face, a little clumsiness in his movements, and some irritability of temper. Since that time, he became as healthy and strong as ever he was. The patient was closely watched during the course of his illness, but the doctor failed to detect any morbid mental manifestations that seemed to indicate injury to any distinct phrenological development.

It will be seen that no disturbance of functions took place commensurate with the injury, nor were they such as would be expected by the school of surface localizers.

In the Montreal Hospital Reports for 1879, we have two cases recorded. The first is a case of a wound inflicted by a swiftly-revolving circular wood-saw. It produced serious lesion in the central part of the first and second frontal convolutions on the left side. The skull wound extended in an oblique direction from above the outer angle of the left orbit across the frontal, through the anterior superior angle of the right parietal and terminated about the centre of this bone. It had penetrated through the membranes, and at the central part the brain substance was lacerated and exposed and could be seen pulsating. The *post mortem* revealed a large rent extending from the longitudinal sinus downward and outward to a point a little anterior to the beginning of the fissure of Sylvius. The central portions of the first and second left frontal convolutions were completely destroyed. The patient was unconscious for about ten minutes after the accident, but when taken to the hospital became *quite conscious* and at that time had no paralysis; nor are we told that



either one or the other supervened before death, which took place two days after the accident.

In the same Hospital Reports, the history of a second case is given: A young man, aged 22, was accidentally shot by the discharge of a pistol. The bullet entered the skull above and a little in front of the right ear. From the first he was perfectly conscious, *not paralyzed*, and gave a rational account of how it happened. A probe was inserted into the wound, and it passed freely into the frontal lobe in the course of the bullet. Pulse 60; no elevation of temperature. The accident happened March 8th, and he died of consumption, Aug. 12th following; but between these two periods there was no unusual mental disturbance. Without giving the details of the autopsy, suffice it to say, that the bullet entered the brain substance in the right inferior frontal convolution, just in front of the ascending branch of the Sylvian fissure. From this point the course of the bullet was upwards and forwards, passing out at the inner surface of the frontal lobe and lodging between the brain substance and the falx, where it lay surrounded by a firm membrane. A firm membranous canal marked the course of the bullet, and the brain substance about this was somewhat softened. This extensive destruction of brain tissue did not disturb the mind.

M. Flourens, of Paris, some years ago, experimented on animals, not only to show the curability of brain substance, but also to demonstrate how much brain tissue can be injured without the untoward physical and mental results formerly apprehended and dreaded. He trepanned the skulls of dogs and rabbits, made a small opening through the *dura mater* into the substance of the brain, and then put bullets into the wound. These bullets gradually penetrated through the cerebral matter by their own weight. When the ball was small, he found that the whole thickness of the lobe of the brain, or of the cerebellum, might be traversed by it without occasioning any symptom or disturbance of function. The fissure made by the passage of the ball remains for some time as a canal; it then closes up and cicatrizes. (*L'Union Med.*, 1863.)

Dr. Thomas Smith, Surgeon to St. Bartholomew's Hospital, London, gives, in the *London Lancet* of January last, an interesting case in which the patient made a good recovery without loss of mental or physical power. A man, 35 years of age, shot himself with a revolver through the head. The bullet passed in at one temple and out at the other. Half an hour after the accident the pupils were found to be natural, pulse feeble, and respiration natural. The patient was quite conscious, and answered questions correctly concerning his name, age, and address, and of his own accord. He was an educated man and spoke in German, but when addressed in either French or English he would reply in the corresponding language. He showed no signs of mental incapacity, nor was there any loss of motor power. He vomited a good deal at first, and at that time blood and cerebral substance were forced from the wound in the right temple. For several days he became quite irritable and had a few delusions, but no functional deprivation. On the forty-third day after the wound was inflicted he became quite well. At first a probe was passed its whole length into the wound and across the head without meeting the slightest resistance. At first the special senses were very slightly impaired; but all recovered their tone before he left the hospital, except the sight which was slightly impaired. As regards the course of the bullet in this case, Dr. Smith says: It is certain, from the position of the apertures of entrance and exit, that it entered the outer surface of the anterior lobe of the brain, a little above the level of the highest part of the roof of the orbit, and that it emerged from the left anterior hemisphere at a spot rather further back and at a slightly higher level. From the large effusion of blood in both orbits, which so rapidly followed the injury, there is reason to believe that in its passage across the skull the bullet fractured the roof of both these cavities. From the free and persistent epistaxis, it is probable that the cribriform plate of the ethmoid, or some part of the roof of the nasal cavity was broken into, while there was evidence, from the symptoms, that the olfactory bulbs did not escape disturbance or injury. It may be said

that there is no direct proof that the left hemisphere of the brain was wounded at all; that the bullet may have run over the roof of the left orbit and up the inside of the skull to its point of exit from the bone. The surgeon is sure, however, that the probe traversed without any sensation of resistance, both hemispheres, and one would think it impossible that a bullet of the size and weight indicated, after passing through one side of the skull, could have knocked a piece of bone clean out of the opposite side unless it impinged upon the inner surface of the bone in a direct line. As further proof, pulsation and respiratory movements were observed in the blood tumour over the aperture of exit, and these were so forcible as to indicate that the interior of the brain was in direct contact with the ecchymosis. It is certain that the part of the hemispheres that was damaged was the anterior frontal portion just above the orbits. Has this part any functional centre? If so, where is the evidence of its being necessary, seeing that both frontal lobes were injured seriously, without any immediate results in proportion to the lesion inflicted? Is this an organization put in more to fill up than to be of use to its neighbours? I had the impression Nature had no garret filled with useless furniture. Some functional centres must have been badly broken up by this destructive intruder.

About seventeen years ago I was called to visit a boy, aged 13, who had been kicked by a horse. A section of the skull was crushed in on the right side, near the median line, in the upper part of the frontal and parietal bones. One of the nine pieces fractured and detached from the surrounding bone had been driven into the substance of the brain, over an inch, in a perpendicular direction. The membranes were lacerated very much and brain substance, within a few grains of an ounce in weight, protruded through the wound much broken up, some of it hanging down upon his cheek. At the time I first saw him he was comatose. I extracted the bones, cut away the ragged edges of the membranes and the lacerated brain substance. Consciousness returned immediately. His temperature re-

mained normal; his pulse did not rise at any time above 96. He did not lose a night's sleep nor a meal after the evening of the accident. No febrile symptoms intervened. There was no paralysis, nor perversion of any of the organs of special sense. There was no difficulty in speaking. A large cavity remained. He afterwards went to school to the same mistress as before, and she informed me that with the exception of a certain irritability of temper when thwarted (which he did not possess before), he was as intelligent as ever, and could learn his lessons with the usual aptitude. This was especially noticeable in mental arithmetical exercises. He was under my observation for several years after the accident. After he was aroused from his comatose condition, consequent on compression, his special senses were unimpaired; his locomotion and grasping power normal; and his bodily health good in every particular.

These examples might be indefinitely extended. Medical literature is full of evidences of destruction to the brain matter of the cerebrum and cerebellum without any serious impairment of mental power or physical functions. Let a brain be taken, and wires passed through it to indicate the course of the missiles in these cases I have mentioned, and it will be seen that brain substance has been injured in almost every conceivable direction, yet with no results at all commensurate with the lesions inflicted. If these parts are motor centres, then have we the miraculous phenomena of organic operations without an organ; of varied and distinct functions without a motive power; of uniform results without an efficient cause. Were we even to consider the brain a dual organ the difficulty would remain, where corresponding sides are simultaneously injured. In all the dual organs of the body we find sudden injury to one is always followed by imperfect work in its fellow until time is given to allow provision to be made for the extra labour imposed. When we find no impairment in function consequent on destruction of *one* so called motor centre, we are led by uniform analogy to doubt a doctrine so anomalous and contradictory. At least, it is better to receive with caution a theory which is being accepted, based upon exceptional examples, which do not account for the physical results, except in isolated cases. The mental effects seen, as consequent upon brain injury, would prove too prolific a theme for present investigation.



# HIP-JOINT DISEASE OF FIVE YEARS' STANDING—REMOVAL OF HEAD, NECK, AND GREAT TROCHANTER OF FEMUR—RECOVERY, WITH USEFUL LEG.

BY R. WHITEMAN, M.B., SHAKESPEARE, ONT.

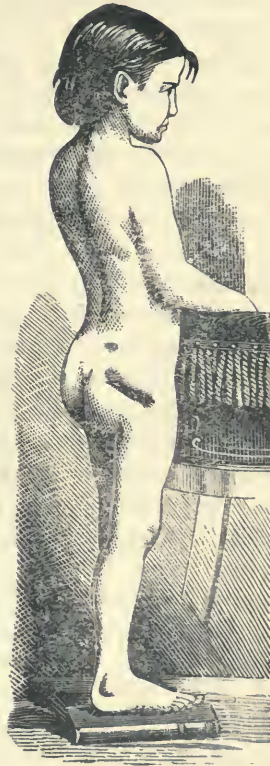
On the 12th of July, 1880, I was requested by Mr. David Hyde, a farmer of North Easthope, to go to his residence, about three miles distant, and see if I could do anything to relieve the sufferings of a grandchild of his, for whom all hope of recovery had been abandoned.

On arriving I found her in a most pitiable condition. During my visit the following facts were brought out, of some of which I was aware before: Name, Mary Riddell; age, seven years; father died of phthisis when she was two years old; mother healthy.

Her hip must have been injured about the time of, or before her father's death, as she had never been able to walk properly. When between two and three years of age she was taken to Dr. D. B. Fraser, of Stratford, who pronounced the case to be one of hip-joint disease, explaining to the friends that it would be necessary to confine her to bed for some weeks; and also pointing out the serious nature of the disease. The friends, however, did not see fit to place her under his charge, but concluded to take her to a Mrs. Greenley, of Guelph (I think that is the name), who professes to have a gift of healing all manner of diseases by a somewhat vigorous laying on of hands, and who certainly has a gift of telling a very plausible story, and generally without the slightest regard to truth or scientific facts. This gifted individual contrived to humbug them for between four and five years, and persuade them that she would cure the child, claiming credit for all nature did in the way of providing for relief of pain, and always accounting in some mysterious way for relapses. Her rubbing over an acutely inflamed joint could not be otherwise than injurious; still the friends, with a faith which would have done credit to a better cause, persisted in believing that she was benefitting the child.

On attempting to examine the child, I found

it would be impossible to do so without putting her under chloroform, as she would cry violently when I attempted to go near her; in fact, I could hear her crying with pain when forty rods from the house. She could not sleep on account of starting pains, and her screams at night kept most of the family awake. I found her pale and emaciated; the right leg drawn up nearly at a right angle to the body and crossing the left. She would not allow me to take her temperature or count her pulse. But I could see on the hip three



openings from which pus was running—one near the crest of the ilium where the scar appears in the cut; the other two in the gluteal region represented nearly by the extremities of the large scar shown in the cut. The right leg was much smaller every way than the left. I told Mr. Hyde, on seeing the child, that if he had still any faith in Mrs. Greenley, or any notion of going back to her, I would rather not touch the case or have anything to do with it; and if I took charge of it I would wish another physician with me, as

she would have to be put under chloroform in order to ascertain the condition of the hip, and if an operation was necessary it had better be performed at the same time. I was then informed that Mrs. G. had given up the case, stating that she could do it no more good (?) until it got old enough to understand how to take care of itself.

—The case was then put into my hands, and I arranged for a consultation with Dr. D. B. Fraser on the 15th. We began about two o'clock p.m., Dr. F. putting her under chloroform in her bed, when we removed her to a table in an adjoining room prepared for the purpose. We then found that there was fibrous ankylosis, with contraction of muscles, which rendered it impossible to straighten the leg. There was extensive suppuration all over the gluteal region, and pus flowed freely from the whole three openings when pressure was applied over the glutei. In order to ascertain the state of parts about the hip I ran a probe into the one opening, represented by extremity of scar, and out at the other. I next followed the probe with a scalpel, laying the intervening space open. It did not bleed much, and on washing away the pus and blood I found the muscles beneath gangrenous, so that the finger could penetrate their substance. With the probe I could feel dead bone, and after a little probing with my finger I found that the capsular ligament was open, and could pass the finger into the cavity of the acetabulum, where I could find pieces of its walls loose, and the head of the femur very rough and uneven to the touch. I then stated to Dr. Fraser that I believed the head of the femur and part of the acetabulum to be diseased, and that our only hope of benefit to the child was in removing all the dead bone we could find. To this, after a careful examination for himself and a little hesitation, he agreed. So I proceeded to exsect. Keeping the patient still under chloroform, I first extended the lower part of the opening already made down to the outer side of the great trochanter, and then directing the blade of the scalpel down the outer side of the femur, extended the incision for about four inches. At this stage matters became serious, as the patient's limbs began

to contract spasmodically, and her breathing became irregular, so that we had to diminish the chloroform. I then began to loosen attachments, so as to get the head of the femur out of the acetabulum. This I found the most difficult part of the operation, and would have been much better of the assistance of another surgeon, as owing to the state of the patient, Dr. F. had to give most of his attention to the chloroform. However, I gradually got away the remains of the capsular ligament and ligamentum teres, and then, with the assistance of Dr. F., succeeded in getting the head freed from the acetabulum. I then sawed through the bone just above the lesser trochanter, taking care not to injure the psoas and iliac muscles, thus removing the head, neck, and great trochanter; and, finding some necrosed bone in the acetabulum, I took out two pieces—one from the rim, the other from the side. I found that I could now extend the leg nearly straight, which drew out the tensor vaginae femoris, which, however, I concluded not to cut, as I expected that continued extension would overcome its contraction. I then brought the leg into as good position as I could get it; washed out the wound. There was very little blood lost in the operation. Sewed up the portion over the femur, and put a piece of carbolyzed lint into the other portion. We then put on a long splint, with arrangements for extension by weight, and placed her in bed.

The operation occupied about one hour. Her temperature before the operation was 100°. Pulse, when under chloroform, 100; after the operation her pulse was 138. I kept a record of her condition, made at each visit, from which I make the following extracts, as there is no object in giving it all:—

July 16.—Pulse, 127; after dressing, 120; temperature, 98.5°; vomited; opium powders given to relieve pain; still slept better than usual before the operation.

July 17.—She is very excitable, and much afraid of my visits; will take no medicine; vomits if they start to get it; pulse, 132; temperature, 98.5°; had starting pains occasionally through the night; moved her bowels by injection; have her on fracture



bed, with hole under hips; before I left, pulse 120.

July 18.—Pulse, 125; temperature, 98.5°; after dressing, pulse 114; eats a little; slept well last night, better than for several months; put 4½ lbs. weight on leg; it is nearly straight; no thirst.

July 22.—Visit with Dr. F.; we find pulse 108; temperature, 98.5°; she eats and sleeps well; has no pain; we now put the leg straight.

July 23.—Pulse, 108; had pain last night along tensor vaginae femoris; gave three-quarters-grain of opium, and allowed hips to sink a little, after which she complained no more; feels well; there is considerable sup-puration.

During all this time I applied carbolic dressings, and had the wound syringed out daily with a two to three per cent. solution of carbolic acid. From this time she began to eat heartily. I at length got her persuaded to take the following:—

R Syr. ferri. iodidi.....℥ 3ss.

Ferri. et ammon. cit..... ʒi.

Aquæ. ad.....℥ ʒiv.

A teaspoonful 3 times each day. Ft. mist.

This she took without much trouble, and began rapidly to improve on it, and as her health and strength improved the discharge diminished. Pulse varying from 100 to 116.

August 24.—Has a good appetite; never complains of pain unless hurt in dressing; has gained very much in flesh; the right leg now as large as the left, with about half an inch shortening. She can sit up, and there is very little discharge. She can allow the limb to be freely moved without pain, and can move it herself. I now applied a bandage to the hip, modifying the Sayre's splint for the purpose, and allowed her to go on crutches, but warned her not to put much weight on the leg lest it should shorten. I also had a pair of strong shoes made for her, with one pound of lead in the sole of the right one. From this time I saw but little of her, but frequently heard of her being around through the fields climbing apple trees, and through the barn; in fact, being in perfect health until January 20, 1881. She had worn out a strong pair of boots when I had the photograph taken, which shows her condition better than I can describe it. There has been no discharge for some months, and she is as healthy and happy as any child; can walk without crutches, though I advise her to still use one. She has fair motion of the hip in every direction, with about three-quarters of an inch of shortening.

## LUXATION OF HEAD OF FIBULA.

BY WM. OLDRIGHT, M.A., M.D., TORONTO.

The following case may be of interest on account of its rarity. Erichsen mentions only three cases occurring in the practice of himself, Boyce, and Sanson, respectively. Gross says "only a few examples are on record," and particularizes only the case of Boyce, above mentioned.

On the 19th of Nov., E. F., aged two years, was brought to my office. His mother stated that two weeks previously he had fallen to the floor off a chair on which he was sitting, and that during the two weeks which had elapsed he had a difficulty in walking. Sometimes he would use the leg for a day, and then would not be able to use it for a couple of days, and so on. Thinking it was only bruised or sprained his parents had delayed bringing him to me.

On examination I found the head of the fibula was displaced backwards, could readily be replaced, but would, of course, just as readily slip back again off the facet. This proceeding did not seem to cause much, if any, pain.

I immediately applied a pad behind the head of the fibula, secured it in its place with "Surgeon's plaster" and bandaged the limb.

On the following day I applied a plaster of Paris splint, with pad and plaster as before, having previously told the parents I would require assistance in so doing, and Dr. McFarlane was called in. I had also warned the parents of the unsatisfactory nature of probabilities, in which view Dr. McFarlane joined. The splint was removed and re-applied from time to time, and absolute and constant immobility was maintained till the 1st of January, when, on the little fellow moving the leg very slightly, the head of the fibula was found to slip backwards quite freely. I then mentioned the probability of having ultimately to discuss the propriety of some operative procedure, and told his mother I would be willing that they should call in some other surgeon if they so desired. She called upon Dr. McCollum who saw him with me, on the 4th January, and while recognizing the probability of an operation being ultimately necessary, recommended the continuance of the previous treatment for several weeks longer at any rate. And so the matter at present stands.

50 Duke street, Feb. 1st, 1881.

## SWALLOWING OF FALSE TEETH AND PLATE—DEATH FROM HÆMATE- MESIS.

BY J. H. GARDINER, M.B., L.R.C.P. LOND., ETC.

On Jan. 20th, 1881, Mrs. B—, æt. 33, was supping some soup, when a plate and two false teeth attached became loosened and slipped down her throat. Violent retching followed, lasting for several hours, but was finally allayed, whether from the stomach becoming accustomed to the foreign body, or from Bismuth freely administered, I do not know. A dull, heavy pain was complained of over epigastrium and in the back over region of stomach, which remained until death. The retching at times recurred, but only slightly. A difficulty in swallowing was complained of, even liquids causing pain. I ordered her to remain in bed, and to take bread and milk, corn starch, or any fluid or mucilaginous food. My instructions were not followed; but the patient persisted in being around and doing her usual "housework." Just one week after the accident happened, the patient was seized with violent hæmatemesis, accompanied with purging. Dr. Charles Moore, Sr., saw the case with me, and we agreed as to the cause of the hæmorrhage, viz., the severing of one of the arteries of the stomach. Ergotin was used hypodermically in eight-grain doses every three hours. All efforts of treatment by the mouth only aggravated the symptoms. The vomiting soon ceased, but the purging continued until the end; and 17 hours after the appearance of the first urgent symptoms the patient died. In the absence of an autopsy, I can only say that I think the accident was caused by a sharp angle of the plate, which was broken previously, being caught in a fold of the stomach near the cardiac orifice, and this had severed one of the arteries of the stomach. Now, in a similar case where one is certain that the foreign body has become impacted, what would be the best line of treatment? The wait-and-see-what-will-turn-up style resulted in my patient turning under. Could some instrument not be devised to remove, or, at least, to break up, a foreign body in this situation?

London East, Ont., 5th Feb., 1881.

## THE TREATMENT OF LUPUS AND RODENT ULCER.

BY JOHN FERGUSON, B.A., M.B., L.R.C.P. EDIN.,  
L.F.P.S. GLASG.

The treatment of the above diseases has long been one of the weak points in surgery, and very various methods have been from time to time suggested, which have either led to disappointment, or been attended with but partial success. For some time the chief points in dealing with these affections, as is well known, consisted in constitutional remedies, and the local application of various caustics, such as strong nitric acid, chloride of zinc, and potassa cum calce. The so-called specifics have been largely used, and arsenic, the iodides, or mercury has entered into almost every formula. This is due to the prevalent belief among many that Lupus, in its various forms, and Rodent Ulcer are often caused in some remote way by Syphilis. That constitutional remedies are valuable, there is no doubt, when suitable selections are made; but, when given in a sort of hap-hazard manner, can only cause disappointment to the patient and bring discredit on the surgeon. Lupus may sometimes be due to a syphilitic taint; but it is very doubtful if Rodent Ulcer can ever be traced to such a cause, and the few cases occurring in a syphilitised constitution may be mere coincidences. In such cases, it is clear, "specifics" will avail very little. The proper use of caustics is also beneficial; yet they should seldom, or never, be alone trusted to, as local means of radical cure. I purpose briefly to give the results of observations on the operations of others, and my own experience in two cases of Lupus and one of Rodent Ulcer.

The operative treatment is very simple, and is as follows: After the patient is anæsthetised, the whole of the diseased tissues are freely and thoroughly removed with a Squire's Scarificator, or a Volkmann's spoon, and the fresh surface well touched with a solution of chloride of zinc of the strength of 40 grains to the ounce, or nitric acid may be used in its stead. If the operation be near the mouth or nose, the patient ought to be allowed to recover pretty fully from the anæsthetic before the



application of the caustic, lest any of it should be swallowed. A light water dressing is then used, and a healthy granulating surface springs up in a few days, on which any of the ordinary plastic operations can be performed.

I have seen the above operation about two dozen times; and, so far as I have been able to ascertain, with universal success. It has been done by myself on a case of *Lupus non-exedens*, one of *Lupus exedens* and one of *Rodent Ulcer*. The two former are completely cicatrized, while the latter exhibits a healthy healing surface. These affections being purely local, their removal can be made complete and the cure thorough.

An excellent after-dressing may be made by soaking thick, soft lint in a saturated solution of boracic acid, and applying it to the wound. This dressing is a clean, non-irritating, and, at the same time, antiseptic one.

Newcastle, Eng., 24th January, 1881.

EARACHE.—“In the course of practice you will often be called upon to attend a case of Earache. This means, pathologically speaking, acute inflammation of the *membrana tympani*. Now, in such a case you may quickly subdue the inflammation, relieve the patient from the excruciating pain he is suffering, and save him, perhaps, from subsequent confirmed deafness. The treatment from which such a very desirable result may be obtained is similar to that which you will find so beneficial in analogous cases of eye disease—viz.: leeches behind the ear, *hydrarg. c. cretâ* and *belladonna* powders, with warm fomentations.” — *Prof. Wharton Jones, F.R.C.S., F.R.S., in London Lancet.*

#### ROYAL COLLEGE OF SURGEONS OF ENGLAND.

—Great and much-needed reforms have lately been effected in the examinations of this ancient corporation. The preliminary educational examination, hitherto conducted on its behalf by the College of Preceptors, has been abolished—this regulation to take effect after the 31st December next. The examination in medicine has been extended, and midwifery at last made a compulsory subject. This qualification will, therefore, once more rank upon a par with the L. R. C. P., Lond.

#### A CASE OF LITHOLAPAXY.

BY L. MCFARLANE, M.B., TORONTO.

On the 12th of December, I was sent for to see Mr. McQ., aged 59, who informed me that he had enjoyed good health until about one year ago, when he began to suffer from pain in making water, and a sense of weight and uneasiness in the anus and perineum. The urine, at times, was mixed with pus and blood.

I suspected stone, and on introducing the sound, met it without any difficulty. The stone measured one and a quarter inches in diameter.

I asked Dr. Aikins to see the patient with me, and on a careful examination, finding the urethra capacious and no enlargement of the prostate gland or any unhealthy condition of the genito-urinary organs, we decided on lithotomy.

With this object in view, I dilated the urethra sufficiently to admit Bigelow's Lithotrite. Two days afterwards, with the assistance of Dr. Aikins, the patient was aetherized, the stone seized, and crushing commenced and continued, until the fragments were thoroughly pulverized. Bigelow's Evacuating Apparatus being used, from time to time during the operation, to draw off the debris.

The sitting lasted for upwards of three hours. The patient was kept for one week, from the date of the operation, in the recumbent posture, and, at the end of that time, being anxious to record his vote for Mayor, I allowed him to get up and go to the polling booth.

He has since been perfectly free from pain or any inconvenience.

It might be supposed from the length of time required to pulverize the stone, that a great deal of irritation would be produced; but, if care is exercised during the operation, this can, to a great extent, be avoided, and the evacuating apparatus being used while the patient is under the anesthetic, saves him from a great deal of pain and suffering, which he would otherwise have, if allowed to void the debris by micturition.

In the case of my patient, although small quantities of pulverized stone were passed for a couple of days after the operation, the irritation was small compared to what it would have been had he been subjected to several sittings, and the debris allowed to pass subsequently.

### Selections: Medicine.

#### ON THE TREATMENT OF BRIGHT'S DISEASE; WITH SPECIAL REFERENCE TO THE USE OF DIURETIC REMEDIES.

BY W. T. GAIRDNER, M.D. (GLASGOW).

Dr. Gairdner said that the present communication was to be viewed simply as an abstract, the historical and other details on which it was founded being published in the *Glasgow Medical Journal*. He had been long of opinion, as the result of more than twenty-five years of hospital experience, that the English practice in Bright's disease, and especially in acute and sub-acute cases, has been too much founded on the conception that the kidney, like an inflamed organ, must have, as nearly as might be, entire physiological rest; and hence that diuretics were to be avoided, even at the risk of their requiring to be replaced by more perturbatory practice. Dr. Gairdner did not hold that diuretic treatment was alone sufficient, or even in all cases expedient; but he held that the mere abstinence from diuretic treatment, or the doctrine that such practice was to be regarded with suspicion in the cases in which the simpler saline diuretics could be brought to act, was opposed to the teaching of experience. In the London schools, in particular, the teaching adopted for many years was that the occurrence of active diuresis, under remedies especially adapted to that end, was to be avoided, and that it was better practice, in most cases, and especially in acute and sub-acute cases, to aim at purging the bowels continuously by the strongest and most irritating cathartics, than to give scope to the kidneys to respond gradually and gently to such remedies as cream of tartar, potash salts, and digitalis. The position here referred to has been modified of late years by the admission: 1st. That spontaneous diuresis often, if not invariably, occurred in such cases as a kind of crisis, or as the first step in the cure; 2nd. That (as Dr. Dickinson, in particular, had emphatically taught) the copious imbibition of "clear spring water," in quantities such as to make it practically one of the

most active of diuretics, tended to the relief, rather than to the obstruction, of the kidney in its physiological work; in other words, that flushing of the obstructed tubuli uriniferi, and general furtherance of the true physiological activity of the kidney tended (as Dr. Christison long ago showed) to the diminution of the pathological disturbance of functions as indicated by albuminuria, deficient excretion of urea, and dropsy. Dr. Gairdner regarded it as in accordance with clinical experience, apart from the theory that, whenever the simpler diuretics would act at all in such cases as were usually treated by means of elimination, their action should be furthered and encouraged, in preference to other modes of elimination. While he did not at all discountenance the use of purgatives on the one hand, or of diaphoretics on the other, in cases in which they were specially indicated, or in which diuretics could not be brought to act, he was always disposed to make such simple diuretic practice as was indicated above the key-stone of the treatment, and to consider it as more in accordance with nature, and with the spontaneous tendency to crisis above-mentioned, than the use of the stronger drastic purgatives, or even of medicinal diaphoretics, or the too often repeated and somewhat enervating use of warm baths, or of air and vapors at a very high temperature. Diuretics, indeed, not unfrequently failed; but so also, not unfrequently, did all the other remedies mentioned. It must also be admitted that the reasonable regulation of the skin and of the bowels was an essential part of good treatment in most cases of Bright's disease, whether attended or not with dropsy; and that in certain cases—e.g., of immediately threatening uræmia, drastic cathartics were sometimes the only method that could be trusted for immediate relief. In such cases, Dr. Gairdner acted on the presumptions derived from Bernard and Barreswil's well-known experiments, as well as on empirical data; showing that the elimination through the bowels of excretory matters which, if retained, were dangerous to life (and notably of urea and its congeners in the form of carbonate of ammonia) might be rationally and safely accomplished for a time, at least, so as to save life and conduce to present comfort. But



he regarded this perturbative course as only a temporary phase of treatment, necessary in some cases, and to be supplanted as soon as possible by the more natural and physiological determination of the liquids towards the kidney. Hence the preference accorded in his practice to cream of tartar, which in its various forms of powder, electuary, and solution, and in certain cases in combination with jalap or gamboge, might be made to serve any and every necessary purpose of elimination, from the most active catharsis to the mildest diuresis, coinciding or not with the natural diuretic crisis, so much insisted on by Dr. George Johnson. By the judicious use of formulæ by no means complex, it was usually possible to graduate catharsis into diuresis, so to speak, in such a way as to gain whatever advantages resulted from the former practice, while at the same time seizing the earliest opportunities of inducing a true renal crisis, whereby the cure, if possible at all, was usually best completed. The exclusively diaphoretic practice of Dr. Osborne of Dublin seemed to have been tried and found wanting, and in a measure laid aside, until recently revived in another form in Germany, particularly by Bartels, whose admirable articles in Ziemssen's *Cyclopædia* would probably give rise to new elaborate trials of Turkish and vapour baths. Dr. Gairdner had often employed these with benefit; but he thought that these benefits would be exaggerated, if they were so employed as to shut out diuretics, or to divert habitually all the available liquids of the body for long periods together to one emunctory, and so to starve the supply of liquids to the kidney. In a few cases of great obstinacy, however, a certain amount of temporary benefit appeared to result from the hypodermic employment of pilocarpin in doses of one-eighth to one-fourth of a grain every second day. The limits of expediency in the use of such perturbative and medicinal diaphoresis had, however, to be determined by careful researches. The same remark applied, in Dr. Gairdner's opinion, to blood-letting, which, at one time a frequent and even a very favourite remedy in the acute and sub-acute cases, had in later years almost gone out of date, but which had been yet more recently revived by several observers and

practitioners of good standing. Several points of modern theory and advanced experimental observation might be quoted as in favour of such practice; but it was not the object of the paper to enter into this question, and all that could be said in the meantime was that it would be a very extreme assumption to reject *in toto* the evidence as to the beneficial results of blood-letting in scarlatinal and other forms of acute renal dropsy. In conclusion, Dr. Gairdner said: "Finally—and to put into a single sentence the main object of this paper—I by no means claim to have discussed at all completely the treatment of Bright's disease; nor have I even alluded to several remedies—*e. g.*, gallic acid, benzoic acid, fuchsin—of which I have made personal trials with various results. But I hope to have shown, once for all, that in almost all stages of the disease there has been an undue tendency to depreciate or exclude diuretic remedies; and that these, judiciously employed, without pretending to an absolute supremacy, are at once the safest and in many cases the most effectual means of dealing with the dropsical symptoms; while, as Dr. Christison has pointed out, their legitimate function is not merely to get rid of a single symptom, but, by aiding the natural process of excretion by the kidneys, to ward off the dangerous accumulations in the blood which lead in time to what is called uræmia. To restore by remedies this natural function, we must needs employ, in any case, methods of elimination that are more or less closely allied in their action to the physiological processes which it is desired to arouse and quicken; and hence, as I venture still to be of opinion, the experience of ages, here quite in accordance with a sound theory, has practically demonstrated the advantage of the use in such cases of the cream of tartar, in its solid as well as liquid forms of administration, followed or accompanied by other mild diuretics or by digitalis—a mode of practice extending back, as we have seen, to the last century, if not to much earlier periods, and only apparently discredited by prejudices arising from the pathological researches of Bright. My argument in this paper is, that the principle of this practice, or the practice itself, ought to be carefully preserved, or restored again more generally and systematically, in the treatment of this disease. As to the employment of tonics, nutrients, chalybeates, and other hæmatics, in the later stages, there is practically a universal consensus of opinion."—*British Medical Journal*.

## TWO CASES OF INTESTINAL OCCLUSION TREATED AND CURED BY ELECTRICITY.

Boudet de Paris (*Progrès Médical*, August, 1880,) gives two cases of intestinal obstruction successfully treated by electricity. In the first place, the patient, aged 15, had just recovered from an attack of peritonitis, when she was suddenly seized with all the symptoms of obstruction, due probably to the entanglement of a loop among the freshly-formed adhesions. The usual means having failed to give relief, the faradic current persistently applied externally was tried, but without any result. The patient was in a very critical condition, bringing up everything that was given her by the stomach. During the next forty hours the continuous current was applied about every three hours for half to one hour at a time; the negative pole was in the rectum, and with the positive the abdominal walls were dabbed so as to produce interruptions. During these applications the intestines were noticed to be the seat of lively muscular contractions, and eventually desire of going to stool was experienced. At last an evacuation was obtained, and from this moment convalescence was established. In the second case, the author had to do with fecal accumulation due to habitual constipation from deficiency of muscular power. Electricity, in the shape of internal galvanization as above, and abdominal faradization, was resorted to as a last resource. The result was most gratifying. From the first, intestinal contractions were obtained, and on repetition large quantities of excreta were expelled. The author remarks that he has collected fourteen other cases where electricity has proved useful in obstruction. He shows that the superiority of the galvanic current, where paralysis of the intestine exists, is due to the fact that it stimulates much more powerfully the unstriated muscular fibres. The interruptions must be slow, because the contractions of these fibres are not sudden but gradual. Care must be taken not to electrolyze the rectum by using a moderate current. The author used from 8 to 14 Leclanché's.—*London Medical Record and Monthly Abstract*.

LOCAL APPLICATION OF HYDRATE OF CHLORAL IN ODONTALGIA AND PROSOPALGIA.—Three or four large granules (0.03—0.06) enveloped in wadding are inserted into the cavity of the tooth and left there until the chloral is dissolved. Up to the present all the patients thus treated—numbering 38—were cured, as well as many suffering from hemicrania in consequence of carious teeth.—*C. Sporer, in St. Petersburg Med. Wochenschr. No. 35, 1880.*

THE TREATMENT OF ASTHMA.—Several writers, and amongst them Dr. Robert Saundby, of Birmingham, have been advising the painting along the lines of both pneumo-gastrics, a mixture of equal parts of liniment and tincture of iodine. This is repeated each night until the skin is made sore.

In herpetics with erysipelas returning every two or three months and thus continuing for years, the arseniate of soda 1 miligram a day for 18 months, with a break in its administrations at the expiration of the third or the half of that time, generally frees the patient from these returns.—*L'Union Med. du Canada.*

Dr. March mentions that copaiba resin, as well as the balsam, cures sciatica; especially when it persists as a neuralgia after the disappearance of the exciting cause.

## Surgery.

### ANATOMICAL SPLINTS FOR COLLES' FRACTURE.

BY GREGORY DOYLE, M.D., SYRACUSE, N.Y.

Within the last few months I have been in the habit of using what may be properly termed anatomical splints, as they are the true counterpart of nature's form.

When a fracture of the arm is presented to me for treatment, I select a friend or neighbour of the patient, whose limbs are of the same size, or still better, a little larger. On his normal arm, I make a plaster cast in the following manner: Two thicknesses of coarse sackcloth or bagging, are cut into the form of



pistol-shaped splints, these are saturated with a mixture of plaster of Paris and water, and applied directly to the palmar surface of the arm and hand with a roller bandage. While this is being done the model is directed to hold his hand well turned to the ulnar side and at the same time flexed on the wrist and forearm; the palm and fingers forming an arc of a circle. This position is to be held until the plaster is firmly set. After removal it is to be dried and padded, when it is ready for use. The splint is to be applied to the broken arm with a roller bandage rather loosely put on, and is to be tightened or loosened from day to day, as the case may require. No dorsal splint is required, as the bandage serves instead.

I have treated thirteen cases of Colles' fracture in this way, and, unusual as it may seem, I have avoided the deformity heretofore so common.

Patients wearing this splint frequently express a sense of ease and comfort, as the position of the hand is that of complete rest.

In treating fractures of the leg, I make splints on the same principle, except that I apply them, while soft, directly to the patient's limb. On the fourth or fifth day after the accident, when the swelling is generally at its height, the dressing is to be put on. Coarse cloth is to be cut out so as to form lateral splints; these are to be saturated with a plaster mixture and rather snugly secured with a roller bandage, extension, in the meantime, being kept up with a weight and pulley. After the plaster has firmly set and dried the weight may be removed, and if the splints become too loose by the reduction of the swelling the bandages can be readjusted, but not too tightly, as I believe in plenty of room for circulation. The patient with this dressing properly applied, can safely go about on crutches after the tenth or twelfth day.—*International Journal of Med. and Surgery.*

**PEPTONE IN PUS.**—Hofmeister has lately determined the existence of peptone in pus. The quantity varied from .367 to 1.275 grammes in 100 centimetres, and was found to be greater in proportion to the thickness of the pus. The corpuscles contained it in abundance, whilst the serum was free from it.

### ANEURISM OF FIRST PART OF EXTERNAL CAROTID.

At the Royal Medical and Chirurgical Society, Mr. Henry Morris, F.R.C.S., reported a case of aneurism, about the size of a walnut, at the level of the hyoid bone, and just above the bifurcation of the common carotid. It was growing for eight months. Digital and instrumental compression could not be borne, and a catgut ligature was put around the common carotid. Pulsation returned four and a half hours afterwards, but subsided again. During the following two months an abscess formed at the angle of the jaw and pus was evacuated. In November, pulsation again returned and increased. The facial and superior thyroid arteries were ligatured, the sac laid open, and clots turned out, and the bleeding found to proceed from the distal end of the sac. This was ligatured and the patient recovered.

Mr. Morris, in his remarks, said that the anastomoses of the carotid in the neck, play an important part in aneurism near the bifurcation, and that the Hunterian ligature should be supplemented by tying the easily accessible branches.

**EXTENSIVE AND FATAL ABSCESS OF THE NECK.**—At the same meeting, Mr. Savory reported the case of a man with an abscess of the neck, which, on dissection, showed in its cavity portions of the carotid artery, jugular vein and pneumo-gastric nerve. A considerable piece of each was wanting. The opposite ends of the divided artery were from one and a half to two inches apart, the ends of the vein were rather farther than this. Mr. Savory thought the vessels had yielded to the intensity of the inflammation.

**EPIDEMIC ORCHITIS.**—In the *Berlin. Klin. Wochenschr.*, (*International Journal of Med. and Surg.*.) Dr. Heller gives an account of an epidemic of orchitis which appeared in the *out-station* of the Danzig Garrison Hospital, in 1876. During the prevalence of an epidemic of parotitis, twenty-nine cases of orchitis occurred. Three of these were probably due to contusions; eight had been preceded by mumps; and in two, both affections existed together. The remaining sixteen were cases of epidemic orchitis, pure and simple.

**SUGGESTED IMPROVEMENT IN DUPUYTREN'S OPERATION FOR ARTIFICIAL ANUS, AND A SUCCESSFUL CASE TREATED BY IT.**—Arthur E. Barker, F.R.C.S., Eng., having found the usual difficulty in obtaining a closure of the fistula in operation for artificial anus, reports the case of a young man, with a fœcal fistula, the result of a strangulated hernia more than a year before. In examining the fistula with the finger, two constrictions were felt, one at the skin opening and one about three quarters of an inch deeper. The tip of the finger touched the usual "spur" of mucous membrane, which reaches as far as the latter opening. This "spur" was removed by nipping it tightly with artery forceps, and left until they came away, bringing with them a portion of the "spur." They were applied a second time, and a second portion of the spur brought away. Then an India-rubber valve was inserted in the intestine and secured by a wire stitch at each end. The valve laps up against the internal orifice of the fistula. This, for a few days, gave the fistula rest and prevented recontraction of the spur of mucous membrane by directing the stream of fœces against it. The fistula finally opened again, and the valve was withdrawn, but it afterwards healed completely. In cases where the fistula closes completely, he proposes to cut the wire stitches and let the valve find its way out by the anus.—*Synopsized from London Lancet.*

**NERVE-STRETCHING IN LOCOMOTOR ATAXIA.** Within the last few months this procedure has proved successful in subduing the lightning pains and partly restoring co-ordination in some half dozen cases of ataxia. Two years ago Blume tried this method successfully in one case, and recently again in another. Lately Langenbuch, Esmarch and Erlenmeyer, have performed it once each with gratifying results, and M. Gillette has quite recently operated on three cases of M. Debove's at the Bicêtre with complete success in the two former, but the last case is too recent to base an opinion on as yet. The sciatic, we believe, was the nerve stretched in all but one of these cases; the median being selected in the exceptional one.

**SUDDEN DEATH DURING GANGRENE.**—M. J. Parise, writing recently in the *Archiv. Gén. de Méd.*, (*International Journal Med. and Surg.*), on the subject of sudden death in gangrene, first demonstrated by Maisonneuve in 1853, denies the explanation of an acute poisoning of the system, and maintains that "gas develops itself from the decomposed coagula, and collects in the veins of the gangrenous part, but is prevented from advancing further towards the heart by the presence of blood-clots; as soon as the gases have reached a sufficient degree of tension they overcome this resistance and rush *en masse* toward the heart. \* \* \* Therefore, if in a case of acute gangrene, we are prevented from amputating immediately, we should at least make deep incisions into the gangrenous part, in order to avoid a collection of air in the veins, and, if it be indicated, compress the larger veins or ligate them.

**THE CATGUT LIGATURE.**—Recent experiments by G. F. Arnaud, who ligatured the femoral artery of dogs fourteen times with carbolized catgut, go to show that the ligature is completely absorbed; in twelve out of fourteen cases the outer coat of the vessel is uninjured, and in the same proportion the internal and middle coats were completely divided as with the hempen ligature. Senftleben's assertion of the rarity of internal clot is not confirmed. The chief advantage, therefore, of the catgut ligature is its absorption and the preservation of the integrity of the external coat of the vessel.

**RARE TUMOUR OF PHARYNX.**—At the Surgical Society of Ireland, (*Brit. Med. Jour.*), Mr. Barton exhibited a tumour which he had removed from the left side of the pharynx of a woman, aged 22; who stated that she had always felt it in her mouth, but that it had only recently begun to give her trouble. The tumour was found to be covered with true skin, containing epidermis, corium, hairs, sebaceous and sudoriferous glands, &c. In the centre, it resembled an ordinary fatty tumour, except that there existed a mass of cartilage in the pedicle.



## COMPLETE LATERAL LUXATION OF KNEE.

—Dr. T. Hughes, in the *London Lancet*, reports a case of complete lateral dislocation of the knee-joint, in a quarryman who fell thirty yards. The inner tuberosity of the tibia rested on the lower part of the external condyle of the femur. The skin was not torn though greatly stretched. The man died of the other injuries received.

## Midwifery.

## VARICES IN PREGNANCY.

M. Budin, of Paris, has written an interesting monograph upon the varices of pregnancy. The most common varices are, of course, those of the leg. M. Budin points out that the signs and symptoms of varicosities of the superficial and of the deep veins are quite distinct. Those of the superficial veins are familiar to every one. In the case of deep varices there is nothing to be seen wrong with the affected leg, except that it is increased in size. The patient complains of severe pain in the calf, in the popliteal space, and in the sole of the foot; and there is increased perspiration of the affected limb. If such symptoms as these are rapidly relieved by rest, it is probable that a varicose condition of the deep veins is their cause. These varices are not constant in their mode of appearance. Sometimes they only become troublesome after several pregnancies, and then not till the last months of gestation; but in some women they are noticed in the first three or four weeks; one patient commonly first became aware of her pregnancies by the development of the varices. M. Budin also describes the varices of the internal and external genital organs, of the anus and rectum, of the urethra and bladder, and of the trunk and upper extremities. Hæmorrhoids often cause a good deal of trouble during pregnancy, but not danger; they commonly disappear after delivery. If fissure co-exist, it will be best treated by forcible stretching. Varices of some kind occur in from twenty to thirty per cent. of all pregnancies.—*Medical Times and Gazette, Monthly Abstract.*

## Translations.

## INHIBITORY PHENOMENA.

M. Brown-Séquard pursues the exposition of his numerous experiments tending to prove the existence of inhibitory phenomena. Some results obtained by the learned professor appear to contradict the opinion of Claude Bernard, who believed that anæsthetic agents had to pass through the blood in order to arrive at the nervous centres. M. Brown-Séquard declares, in fact, that chloroform may act upon the nervous centres without passing through the circulatory current. He finds a proof of this in the following fact: He removes the viscera, the heart, and all the blood of a frog; then applies chloroform to the skin of the animal. This application produces exactly the same effects as if there had been absorption of the chloroform.—*Le Prog. Méd.*

## STATISTICS OF CEREBRAL HÆMORRHAGE.

BY DROZDA.

Drozda has collected 927 cases of cerebral hæmorrhage, which have been observed from 1868 to 1877 in three important hospitals of Vienna.

In 1,000 patients admitted to the hospital, there were 3 of cerebral hæmorrhage; and in 1,000 deaths, 21 caused by this affection.

Of the 927 cases, there were 410 men and 517 women.

The greatest frequency (28.10%) is from 50 to 60 years. Then follow in decreasing order: 60 to 70 years, 26.71%; 40 to 50, 18.10%; 70 to 80, 13.11%; 30 to 40; 8.42%; 20 to 30, 2.5%; 80 to 90, 1.92%; lastly—15 to 20, 0.72%. Women suffered most frequently at an advanced age.

The termination gives the following relations: recovery, 5%; death, 56%; amelioration or stationary, 39%.

In 534 cases the paralysis was on the right side 270 times, 243 times on the left—21 times paraplegia (1) was observed. In 294 deaths the hæmorrhage was 134 times on the right, 148 times on the left; 12 times on both sides.

As to the seat of the lesion, the cerebral hemispheres were injured 106 times (36.4%);

the corpus striatum with almost the same frequency, 101 times (34.58%); optic thalamus, 70 times (23.79%); the caudate nucleus, 51 times; the semioval centre, 13 times; the pons varolii, 7 times; the cerebellum, 4 times; the corpora quadrigemina, 4 times; the insula, twice; finally, the cerebral ventricles, twice.

As concomitant diseases have been noted—34 times chronic endocarditis, 33 valvular lesions of the heart, 18 pneumonia, 14 Bright's Disease, 8 chronic hydrocephalus, 6 uterine fibromata, 5 hypertrophies of the heart, 5 myocarditis, 5 atrophies of the kidney, and 5 tumours of the brain.—*Lyon Méd.*

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### Correspondence.

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To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

SIR,—Whilst we must regret that so many are laid aside by indisposition, of those who are sacrificing themselves on the altars of their country, discharging at Ottawa the duties we have thrust upon them, still we must try and draw one consolation, namely, that this, in conjunction with other circumstances, is waking them up to an appreciation of "Preventive Medicine." The term is not a very correct one as applied to Sanitary Science, but I use it as it seems *apropos* of the present condition and feelings of our legislators. All who are interested in Sanitary Science must be glad to see that the Government, and members generally, appreciate the fact that there must be some preventible causes for many of our indispositions, and that they are determined to get at the causes and the preventions in their own case. We must, also, feel sorry that at the present day our knowledge and skill are so at fault: one would think it ought not to be a hard matter, with all our knowledge of pneumatics, to draw pure air from the vast dome, full of it, that overspreads our earth, to convey it by pure channels to clusters of hot steam coils, or other means for heating it without defiling it, and to then distribute it for use—pure and warm—and when used and spoiled to carry it out again; and we must feel sorry that this has not been done these many years. But we are glad, as I have already said, that it is now

going to be attended to, and that defective systems of drainage are being threatened also.

We may also live in hope that our legislators, who have these things in their own hands, may see that what is good for the health of a House of Parliament and of its members, is also good for every other building, whether public or private, and for all other groups of people in this fair Dominion; that it would be well to have some organization by which good ventilation might be gained for every school, court-house, factory, gaol, hospital, barracks, printing-office, etc., etc., and by which the dwellers in cities, towns, and villages might be saved from the perils occasioned by the noxious substances with which the soil of our yards and streets is saturated, and from the noxious gases which silently work their way from the sewers into nine-tenths of our houses.

In other places where sanitary precautions and improvements have been enforced, an immense diminution in the death-rate has followed. Is this Canada of ours, with all her boasted education, so hard up that she cannot afford to save the lives of her people? If so, let us take the view of the case presented by Mr. T. H. Monk, in to-day's *Mail*, in which he states, by analogy from what has taken place in more advanced communities, that Ontario would save over one million dollars annually by the organization of a system of Health Boards.

We pay a good sum now for hanging the guilty; surely we ought to be willing to pay something for saving the innocent. Is it not as necessary to protect ourselves from the onslaught of inanimate death-dealing influences, as from those of animate death-dealing men?

It is to be hoped that the Government of the Dominion, and of the several Provinces, will before long come to some understanding, so that we may soon step abreast of the nations that have gone into the front rank in these matters sanitary.

There is, of course, plenty of work to be done beside what I have indicated above, such as regulating the filthy mixtures quaffed in blissful ignorance from wells and other sources; stopping the distribution of scarlet fever scales, etc., in our groceries, etc.; the regulation of noxious trades, the —, well, when the Health Bureau is organized I will give you some more little matters to be looked into. Meanwhile

I remain,

Yours, etc.,

WM. OLDRIGHT.

TORONTO, 22nd Feb., 1881.



# THE CANADIAN Journal of Medical Science,

A Monthly Journal of Medical Science, Criticism,  
and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, MARCH, 1881.

See among Advertisements, notice of Summer Session in McGill University, Faculty of Medicine, Montreal.

## ONTARIO MEDICAL COUNCIL.

At a meeting of the Executive Committee of the Council, held Feb. 15th, the question of the Matriculation Examination came up for consideration, but no decision was reached on the subject. An adjourned meeting is to be held on the 1st of March.

## UNPROFESSIONAL ADVERTISING.

It is seldom we have had the pleasure of being so much in accord with our contemporary of the *Canada Lancet* as, we are glad to say, we find, from his last issue, ourselves to be anent the subject indicated in our present caption. Indeed we had marked for insertion in our columns, as soon as the exigencies of space would allow, the very quotation from the *London Lancet* which concludes the article referred to. Our attention is daily directed to, and our sense of professional decorum shocked by the appearance in the advertising columns of the lay dailies and rural weeklies of the names, office hours, and titles of many practitioners duly registered both in Canada and Great Britain. Unfortunately, our own native qualifications and degrees, are by many not regarded as, even implicitly, imposing upon their holders any restrictions in the indulgence of the desire for

such tradesmanlike and unprofessional publicity; but, it is beyond every shade of doubt that these questionable proceedings are most distinctly frowned down by those in authority in the Royal Colleges and other licensing bodies and, *à fortiori* therefore, the Universities of the Motherland. We have often felt strongly disposed to call the attention of the censors of these bodies to the frequent infringement (with all the impunity assured by boldness) of both their expressed and implied canons of decency and decorum by members practising in the colonies. We were lately grieved to observe placarded over the blank walls of the city the notice, in giant capitals, of the removal of residence of a highly respected and respectable member of the profession. When such things are possible what measure of allowance must we make for the smaller fry? Again, a card forwarded to us from Collingwood presents upon the face the name, office hours and residence of a well-known local practitioner of some standing, and upon the obverse a notification of a recent visit to the centres of professional learning and experience upon this continent with an expressed sense of augmented knowledge and acquired skill in a list of specialties which—by the way—includes them all. The American Medical Press at the present time also teem with complaints of and protests against such and such like evidences of a prurient hankering after publicity and newspaper fame. Shall we then be behind our brethren of the old country, and our cousins to the south of us, in the endeavour to uphold professional dignity and decorum?

Doubtless in consequence of the prevalence of such practices, we find, in the post-office directory for Great Britain, members of the *Medical Profession* classed in the *Commercial* section; and one of the Colleges of Cambridge in its bill of particulars enumerates physicians' fees or *honoraria* amongst "Tradesmen's Bills."

We would remind members of the profession of the celebrated colloquy between the prominent successful charlatan and the poor but deserving regular practitioner, tending to show the acumen and discrimination of the former in the recognition of the fact that 99 fools con-

sulted him, while the one wise man sought the doctor. To our friends of the laity we would venture the admonition that these professional luminaries of the newspapers are very apt to prove the deluding flame in whose pursuit the unwitting moth is singed.

We are glad to have the co-operation of our city contemporary in the endeavour to suppress this growing and hydra-headed evil; and can only trust that this association in one good work may lead to the discovery of many lines of agreement on which we can labour in concord for the public good and professional weal.

#### HOSPITAL APPOINTMENTS.

It is a well-known fact that the General Hospital of Toronto, so far as its general executive management is concerned, is one of the best on the continent. It is also well known that this is entirely due to the active interest taken in it by the Governing Committee, combined with the untiring zeal and administrative ability of the Medical Superintendent. The Hospital Committee has always shown a desire to co-operate with the members of the profession in order to attain the highest degree of excellence in every particular, and with this end in view the Chairman of the Board, Mr. Justice Patterson, not long since, addressed a circular to the profession in this city, asking for their views on various questions connected with Hospital Management. It has also been felt that the system of making appointments to the medical staff is vague and unsatisfactory, although, we must say, that we have no complaint to make about any appointment made during the last few years. At the same time we think it desirable that medical officers should be appointed for a definite term of years, and should then receive, as a reward for their labours, a position on the Consulting Staff, where they will still have an opportunity of giving clinical instruction, and taking the management of complex cases, and performing difficult surgical operations. We cordially endorse the views expressed by our contemporary in a very sensible article on this subject which appeared in its last issue.

We also think it would be in the interest of

the patients, and would greatly benefit the clinical teaching, if assistants were appointed to take charge of the out-door patients. By this management we might have what are called "Out-patient Clinics" given by the assistants, and the regular surgeons and physicians would have more time for bedside teaching, which is so important to the medical student, and through them to the general public. We cannot understand why this has not been done before, as we know of no hospital in the world as large as the Toronto General Hospital where such a system is not carried out.

We have no desire to dictate to the Hospital Committee, for whom we entertain the highest respect, but simply offer the above suggestions for their consideration, under the belief, that in our remarks, we represent the views of the medical profession of this city.

#### THE ACCURACY OF CLINICAL THERMOMETERS.

A CARD TO THE MEDICAL PROFESSION FROM  
THE WINCHESTER OBSERVATORY OF  
YALE COLLEGE.

The competition of business, coupled with the entire absence up to this time of any large observatory in this country paying special attention to thermometry, to which authoritative appeal could be made, has so affected the manufacture of thermometers for medical purposes, that it seems necessary to issue a card briefly indicating the errors commonly found to exist, and to explain why, in this case, the representations of the dealers may be at fault through the want of a proper understanding of the subtle errors to which medical thermometers are liable.

Too great a desire to economize time, good material, and skilled labour has led, in the making of thermometers, to the following faults: 1. The graduation is sometimes started from one point of the scale, near the normal, and the size of the capillary tube is guessed at. No upper point being fixed by the maker, the higher graduations may be erroneous to the extent of several degrees. 2. Too much air separating the index from the column of mer-



cury causes the index to rise with a jerky motion; air above the index forces the index down when the thermometer is taken away from the body. In some thermometers errors from this cause amount to two degrees at high temperatures. 3. New thermometers increase their readings rapidly during the first months after manufacture, so that instruments which were right when made may change their indications as much as two degrees within a year.

It will be seen that these errors are not such as the dealer can readily detect. Even in those cases where a dealer is provided with a standard thermometer with which comparisons could be made, it is a difficult matter to determine the errors of the standard itself, and the unsupported representations of dealers and druggists therefore, though made in perfectly good faith, cannot, from the nature of the case, afford the physician satisfactory evidence that any thermometer he may buy is not affected with errors, which in many instances under our observation have amounted to several degrees.

Following the example of the Royal Society's Observatory at Kew, at which during the past year upwards of five thousand thermometers were examined, this observatory has established a department to which any physician or other person may send thermometers by mail or express, and upon the payment of a small fee receive certificates of their exact errors. The facilities are such that there is no good reason why physicians should not buy their new thermometers furnished with the Yale Certificate by the dealers; in those cases where no certificate is furnished the uncertainty may amount to two degrees. It should be remembered that thermometers which the physician has had in his possession for many months are certain to have had the requisite seasoning, and therefore an old thermometer with a recent certificate is more valuable than a new one, or one about whose age there is doubt.

The Observatory has been called upon within three months to certify about seven hundred thermometers from various parts of our country; the results of this work have demonstrated the gross inaccuracy of the cheaper clinical thermometers as commonly sold and seem to render

expedient the publication of this card calling the attention of physicians to these errors and the great difficulty of detecting them except with the appliances of an Observatory devoted to this work.

LEONARD WALDO,  
*Astronomer in Charge.*

NEW HAVEN, Conn., Feb. 1, 1881.

Single thermometers may be packed in wooden boxes, with cotton wool, and sent by mail. The charge for certifying a single thermometer is 50 cents, which should accompany it. In future no thermometers should be purchased from American manufacturers which have not a certificate of seasoning and a calculation of error accompanying them, since the means of procuring them are now placed very reasonably within the reach of all dealers in these instruments.—(Ed.)

#### PROVINCIAL MEDICAL ASSOCIATION OF ONTARIO.

A Committee from the Hamilton Medical Society, composed of Drs. MacDonald, MacKelcan, Mullen, Rosebrugh, and Woolverton, met the Toronto Committee, in Toronto, on the 22nd of February, to complete the arrangements for the proper organization of a Medical Association for the Province of Ontario. Dr. Covernton having been appointed Chairman of the meeting, and Dr. J. E. White, Secretary, it was decided to hold the first meeting of the Association in Toronto, on Wednesday, June 1st, of this year. A draft of the Constitution and By-laws was drawn up, to be submitted to the Society for approval. It is proposed to have a President, four Vice-Presidents, a General Secretary, four Corresponding Secretaries, and a Treasurer, all to be elected on the first day of the meeting. Several questions were left open for the consideration of the Association, such as time and place of meeting, after the first, amount of annual subscription, &c.

From the great zeal manifested at the preliminary meeting, from all the information we can gather from private sources, and from the numerous favourable letters received by the indefatigable provisional Secretary, Dr. White, in reply to his enquiries, we can with confidence predict a large and enthusiastic gathering in June. We trust that the Profession of the Province will be unanimous in extending a hearty and faithful support to the Association.

## A REMARKABLE CASE.

A somewhat pleasing proof of the advance in medical science is talked of at present in educational circles. It seems that some two years since a young lady in one of the Protestant Commissioners' Schools was obliged to give up her position, having lost the use of her vocal organs. Everything was done for her that could be done with little success, until she was advised to consult Dr. Major. After carefully looking at the lady's throat the doctor discovered what he believed was the cause of trouble, and after six weeks of throat exercise, under his care, the young lady's voice was fully restored. Our reporter called upon Dr. Major, who admitted the above facts, but claimed no special credit for the case. He had not learned that it created any comment in the profession, as hinted by our reporter, and if he had helped the lady he was glad of it. He trusted that her name would not be mentioned, and in fact deprecated any mention of the case at all. In the public interest it is given.—*The Montreal Daily Witness*, Feb. 17th, 1881.

We deeply sympathize with the unfortunate doctor who has been submitted to the indignity of receiving such an unprofessional "puff," notwithstanding the extreme modesty which was so conspicuously exhibited in his interview with the reporter, and his strongly-expressed desire to avoid any "public mention of the case." It may be a source of consolation to some in this vicinity that such accidents are not confined to Toronto.

Three sudden deaths within the pale of the profession have occurred in this city since our last issue. Dr. Harkin was seized with a sideration on the floor of Parliament and shortly succumbed. Dr. Tuck, of Guelph, expired suddenly in the American Hotel from some cardiac affection; and news just reaches us of a fatal accident to Mr. John Perrett, a student of the Toronto School of Medicine, who was struck by a run-away horse while crossing the street and sustained a fracture of the skull. Their respective families have the sincere sympathy of the profession in their great bereavement.

## UNIVERSITY SENATE.

The election of Members to the Senate will take place in May. The retiring Members are T. W. Taylor, M.A., Lachlan McFarlane, M.B., and Rev. Neil MacNish, B.D., LL.D.; and they are eligible for re-election. We are sorry to learn that Mr. MacNish positively declines to be a candidate, as he is unable to attend any of the meetings of the Senate. He is a strong representative man, a thorough friend to the University, and his decision will be a source of regret to the great mass of graduates. At the request of Mr. MacNish and others, Mr. W. G. Falconbridge, who was for more than eight years the Registrar, has consented to be a candidate. His eminent fitness for the position and his great personal popularity will ensure his election beyond a doubt. It would be obviously superfluous on our part to say anything in favor of Mr. Taylor and Dr. McFarlane as we cannot conceive of any excuse for offering them opposition. We, therefore, hope to see Mr. Taylor, Dr. McFarlane, and Mr. Falconbridge elected by an almost unanimous vote.

The election of Mr. Mulock to the Vice-Chancellorship makes another vacancy in the Senate which will have to be filled at the coming election. The name of Mr. J. B. McQuestin, M.A., of Hamilton, has been mentioned for this position. He would make an excellent Member, and if he consents to become a candidate, will, we think, be sure of election.

Mr. Crooks's Bill, at present before the House, provides for an increased representation and a new mode of nomination. We hope to refer to it in our next issue.

We find that the Trommer Extract of Malt is being largely used in this country, as well as in the United States, Great Britain, and Germany. There is no question about the fact that the Malt Extract is a most valuable and efficient remedy in suitable cases, including debility, from its various causes; and there appears to be a general consensus of opinion, that Trommer's preparation is the most reliable in the market. Our own experience certainly accords with this opinion.



In illustration of the amenities of Medical Journalism, we submit the following communication to our readers. Suffice it to say, on our part, that Dr. Nash's second letter referred to (the first appeared in our January issue), did not appear to present his case in any new or different aspect; and that under the circumstances of considerable pressure on our space, it did not seem proper to give our readers the doubtful advantage of its publication. We are happy to be able to add that Dr. Nash is personally an entire stranger to us.

FOREST, Feb. 4th, 1881.

SIR,—I return your paper of this month, having found that my article in answer to the diatribe in your last issue was omitted. You have tried all the *little* means in your power to injure my character, both *morally* and professionally, and had not the *manhood* to publish my letter in answer. Such *contemptible cowardice* is a fit corollary to the *venemous malignity* with which you first attacked me. It is hardly necessary to state that, under such circumstances, you need not send any more numbers of your paper to my address, as they will not be taken out of the post-office.

I remain, Sir,

Your obd't ser't

H. J. NASH.

DRS. THOMAS AND HUNTER'S NEW PRIVATE HOSPITAL FOR WOMEN, NEW YORK.—In answer to special inquiries we may state generally for the benefit of our readers, that the general terms of this Institution are: \$40 per week, exclusive of medical attendance, payable weekly to matron; \$22 per week for medical attendance; operations extra. Charges determined by previous agreement. The usual medical attendance includes two visits weekly from Dr. Thomas, and as many as may be necessary from Dr. Hunter, who resides in the building, 596 Lexington Avenue.

MR. ALFRED BAKER, M.A., has been appointed Registrar of Toronto University, in the place of Mr. Falconbridge, who resigned after holding the position for more than eight years.

TRAINED NURSES.—“We may expect,” says the *London Lancet*, “to hear of the nursing question giving trouble in our transatlantic dependencies. The authorities of the Toronto Hospital are, it is stated, about to establish a scheme for training nurses, their instruction to be undertaken by a lady graduate of one of the schools of England. We hope the experience so dearly bought in the Mother Country will not be lost on the promoters of the enterprise in the far west.”

We may be permitted to reiterate the warning, as well as the expression of the hope that the trustees of our General Hospital will not in any wise commit themselves without a patient investigation of, and due deliberation on, the errors and abuses which do so easily beset this portion of hospital administration.

The following gentlemen have been appointed Examiners for Toronto University: A. E. Malloch, B.A., M.D., University Glasgow, of Hamilton, Examiner in Surgery and Anatomy; F. R. Eccles, M.D., M.R.C.S., Eng., F.R.C.S., Edin., of London, Ont., Examiner in Practice of Medicine and Materia Medica; D. B. Frazer, M.D., M.R.C.S., Eng., of Stratford, Examiner in Midwifery and Medical Jurisprudence; George Wilkins, M.D., M.R.C.S., Eng., of Montreal, Examiner in Physiology and Comparative Anatomy; Professor Pike, of University College, Examiner in Chemistry; Professor Ramsay Wright, of University College, Examiner in Botany. These appointments will give general satisfaction.

TOST v. FREEMAN.—A *rule nisi* has issued in this cause, from the Court of Queen's Bench, to set aside the non-suit on technical grounds; but, in granting the rule, the Court took occasion to remark that had the case been left to the jury and a verdict for plaintiff entered on the evidence adduced, it most indubitably would have been set aside.

Dr. Wm. Osler, M.R.C.P., Lond., Prof. of the Institutes of Medicine in McGill University, has been elected an honorary member of the Toronto Medical Society.

"The Messrs. Henry Lea's, Son & Co., have introduced the half-Russia binding for medical books. The new editions of Flint's Practice, Bryant's Surgery and Thomas' Diseases of Women come to us in this elegant form. The enterprise of this ancient house is exceedingly commendable. The esthetic is never out of place, and the doctor will love his companions all the better for an elegant dress. Whatever differences of opinion may exist on the present state of American medicine, the American profession has just cause to congratulate itself on the high stand taken by its publishers. The civilized world does not surpass these in the excellence of their work." So says the *Louisville Medical News*; and so say we all.

Mr. Stevens, jr., member of the firm of Messrs. I. Stevens & Son, surgical instrument makers, London, England, has opened a branch in Toronto, 274 Yonge street. Such an establishment was much needed in this Province, and we gladly welcome this well-known firm, and hope that they will receive the encouragement they deserve.

The Directors of the Montreal General Hospital have decided to follow the example of the Committee of the Toronto Hospital by appointing a Medical Superintendent to take charge, instead of a non-professional man, (the steward), as heretofore.

CANADIANS ABROAD.—Thomas Kelly, of the McGill School, has passed the Primary Examination for M.R.C.S. John Ferguson, M.B., Toronto; Charles Macdonald, Tilsonburg; Neil McKechnie, M.B., Ont., have been admitted L.F.P.S., Glasgow, and L.R.C.P., Edin.

Dr. Woods, formerly of Streetsville, Dr. McCullough, of Rockwood, Dr. Alan Baines, and Dr. Cook, for some years Surgeon in the Allan Line of Steamers, have lately moved to Toronto and commenced "regular" practice.

Dr. J. Fulton, editor of the *Canada Lancet* has been appointed Professor of Surgery in Trinity Medical College in the place of Dr. Bethune, resigned.

## Book Notices.

*Erysipelas of the Larynx.* By WM. PORTER, A.M., M.D., St. Louis. (Reprinted from *Archives of Laryngology*.)

*Anæmia in Infancy and Early Childhood.* By A. JACOBI, M.D. Reprint from *Archives of Medicine*. New York: G. P. Putnam's Sons, 182 Fifth Avenue.

*A Case of Scleroderma.* By J. E. GRAHAM, M.D.; Lecturer on Dermatology, Toronto School of Medicine, (Reprint from *Archives of Dermatology*).

*Case of Medullary Neuroma of the Brain.* By Prof. WM. OSLER, M.D., M.R.C.P., Lond. McGill College, Montreal. Reprint from *Journal of Anatomy and Physiology*, Vol. XV.

*Caesarean Section with Removal of Uterus and Ovaries after Porro-Müller Method.* By ELLIOTT RICHARDSON, M.D., Philadelphia. Reprint from *American Journal of Medical Science*.

*The Relations of Goitre to Pregnancy and Derangement of the Generative Organs of Women.* By EDWARD W. JENKS, M.D., LL.D., Chicago, (Reprint from *American Journal of Obstetrics, &c.*) New York: Wm. Wood & Co., 27 Great Jones St.

*Illustrirte Vierteljahrsschrift der ärztlichen Polytechnik.* Herausgegeben von Dr. G. Beck, Verfasser des therapeutischen Almanachs. Verlag der J. Dalp'schen Buchhandlung. (K. Schmid) in Bern und Leipzig. An illustrated quarterly account of the new medical and surgical inventions of the world.

*The Medical Record Visiting List or Physician's Diary for 1881.* William Wood & Co., New York.

This List, arranged for 30 patients a week, is well bound, neat in appearance, convenient in size, and so perfect in every respect, that we are unable to suggest any improvement.



*Cutaneous and Venereal Memoranda* By H. G. PIFFARD, A.M., M.D., and G. H. Fox, A.M., M.D. Second Edition. New York : Wm. Wood & Co., 27 Great Jones St. 1880.

The second edition of this little work appears to merit the same general commendation which the first received. It is intended only as a *vade mecum* for the student who cannot afford to buy the larger treatises on Skin Diseases; and whilst it conveys a good deal of useful information in a small compass, it will haply serve to stimulate the appetite for further knowledge in this important and too-oft neglected department.

*The Histology of Granular Kidney* (with figure). By ROBERT SAUNDBY, M.D., Edin., Birmingham. Reprint from *Journal of Anatomy and Physiology*, Vol. XV.

*The Histology of Granular Kidney*, (with plates V. and VI.) By ROBERT SAUNDBY, M.D., editor of *Birmingham Medical Review*. Reprint from the "Transactions of the Pathological Society of London," for 1880.

Two valuable contributions to the Histology of this much vexed subject, demonstrating very clearly the presence of numerous lymphoid cells in the inter-tubular stroma, and strongly supporting the inflammatory nature of the affection, involving all the tissues of the gland,

*Infectious (So-called Ulcerative) Endocarditis*. By PROF. WM. OSLER, M.D., M.R.C.P. Lond., McGill University (Reprint from *Archives of Medicine*). New York : G. P. Putnam's Sons. 1881.

A valuable contribution to the literature of this important subject. The points set forth and ably sustained are:—(1.) That the majority of cases of infectious endocarditis occur independently of rheumatism. (2.) The frequent association with pneumonia. (3.) The production of acute multiple aneurisms of the aorta in this disease; and (4.) certain histological features in the endocardial vegetations and particularly a remarkable fungoid growth in one case. These are illustrated by seven figures.

*Handbook of Systematic Urinary Analysis, Chemical and Microscopical*. By FRANK M. DEEMS, M.D., Laboratory Instructor in

the Medical Department, University of New York. New York : The Industrial Publication Company, 1880.

This little 12 mo. manual of some 30 pages, bound in limp cloth, and costing only 25 cents seems to us eminently calculated to fulfil the author's intention in providing a concise guide in routine urinary analysis for busy practitioners, clinical assistants, and students. It comprises in small compass and tabular form (1) The systematic qualitative analysis of the urine; (2) the systematic chemical examinations of inorganic urinary deposits and the examination of urinary calculi; (3) the systematic microscopical examination of urinary deposits; and (4) the general micro-chemical analysis of urinary sediments. In all these particulars the book appears to be a safe and sufficient guide, and we would cordially advise all students to become its possessors.

*Photographic Illustrations of Cutaneous Syphilis*. Forty-eight plates from life. Colored by hand. By GEO. H. Fox, A.M., M.D. Nos. 4, 5, and 6, (complete in 12 Nos.) New York : E. B. Treat, 757 Broadway.

These plates fully maintain the excellence exhibited in the first three Nos. No. 4 comprises syph. papulosum et pustulosum, syph. pustulosum, syph. pustulosum corym-biforme, and onychia syphilitica. No. 5 figures syph. papulosum humidum, syph. papulosquamosum (2 plates) and, by way of contrast, hydroa pemphigus iris. No. 6 illustrates eczema squamosum (non-syphilitic) syphiloderma squamosum circinatum (2 plates) syph. squamosum gyratum, syph. tuberculosum, and syph. tuberculosum ulcerativum. The artistic execution of these plates is certainly most admirable, and the representation of the affections depicted exceedingly life-like. They will constitute a safeguard and efficient aid in the oft-perplexing diagnosis of cutaneous syphilitic eruptions, and thus in a measure compensate for deficient clinical advantages and experience in this much-concealed and denied affection.

*A Manual of Medical Jurisprudence*. By ALFRED SWAINE TAYLOR, M.D., F.R.S., F.R.C.P., etc. Eighth American Edition, from the Tenth London Edition. Edited by John J. Reese, M.D., Professor of Medical

Jurisprudence and Toxicology, University of Pennsylvania, etc. Philadelphia: Henry C. Lea's, Son & Co. Toronto: Hart & Rawlinson.

This work is so well and favourably known, that an extended review would be quite superfluous. The revision of the book for this edition was the last work of the illustrious author, completed only a short time before his death. The American Edition has the advantage of containing some valuable additions, made by the editor, Dr. Reese, and includes also the notes of the editors of former Editions—Dr. Hartshorne and Judge Penrose. It is a pleasure to peruse a work so pleasantly written, so fully up to the times, and so thoroughly complete in every respect. It is presented in Lea's best style, and, considering the high reputation of this deservedly popular publishing firm, we can give it no greater praise.

*An Elementary Treatise on Practical Chemistry and Qualitative Inorganic Analysis.* By FRANK CLOWES, D.Sc., Lond. From the third English Edition. Henry C. Lea's Son & Co.

The book is specially adapted for use in Colleges and Schools, and by beginners. It is divided into seven sections and three appendices: the first three sections discussing preliminary operations, &c.; the last containing lists of apparatus and re-agents required. The appendices contain the rarer elements and their reactions, and a short account of the spectro-scope. Section IV. takes up the group tests for the metals and acid-radicles. Beginning with the Potassium group, the author passes back to the Silver or Hydrochloric Acid group. Section V. gives directions for the analysis of a simple substance containing one metal and one acid radicle; while Section VI. contains a full Analytical course. At the end of each of these Sections are examples of substances analysed, and the manner in which they should be entered *at once* in the Students' note books.

The fullest descriptions are given of the various manipulations and processes, in order to supersede as much as possible the necessity of a teacher. The chemical notation is used throughout the work, thus economizing space and familiarizing the student with the chemical

formulæ of the re-agents. The Tables are full and numerous; a noticeable feature is their position *across* the page, the convenience of which the student will soon appreciate. The flame colourations and the usefulness of the blow-pipe, as a confirmatory test for the presence of the metals, are clearly put forward.

We can cordially recommend this little work to the notice of students, especially beginners, as well as to teachers, feeling assured that each will receive hints useful to their separate needs.

*A Practical Treatise on Surgical Diagnosis.* By AMBROSE L. RANNEY, A.M., M.D., Adjunct Professor of Anatomy, University of City of New York. New York: Wm. Wood & Co., 27 Great Jones Street. 1880. Second edition, revised and enlarged.

This work was compiled, we understand, at the request of a clinical class of students, and chiefly for the benefit of such, to whom no doubt it will prove a valuable mentor and assistance. If, however, it be trusted to for memorising the necessary facts for passing an examination it will be productive of evil instead of good; and the knowledge so acquired will inevitably prove as fleeting and evanescent as the moments spent in acquiring it. By the busy practitioner it will, no doubt, frequently be found a valuable remembrancer and suggestive reference book in haste. In the second edition the plan of the work has been somewhat altered, "a concise and general enumeration of the etiology and symptomatology of the more important diseases" having been added to the differential tables of symptoms. The book is made up of eight parts, comprising (1) Diseases of the Blood Vessels; (2) of the Joints; (3) of Bone; (4) Dislocations; (5) Fractures; (6) of the Male Genitals; (7) of the Abdominal Cavity; and (8) of Tissues; and is based upon the teaching of the best authorities, whose names and works referred to are cited in a copious bibliography appended. The statements contained throughout are generally as accurate as possible, though frequently too dogmatic, a fault doubtless inherent in and inseparable from the nature of the work itself. It bears the impress and sign manual of a teacher of a class, and will prove helpful to fellow-laborers in that field as well as their pupils. To such we heartily com-



mend it. An excellent index is due to one of Dr. Ranney's pupils, Mr. Henry C. Moir. The type is large and clear, the paper good, the cloth binding solid, chaste and durable—in a word, a handsome book.

*John Hunter and his Pupils.* By S. D. GROSS, M.D., LL.D., D.C.L., Oxon., LL.D. Cantab., Philadelphia: Presley Blakiston, 1012 Walnut Street; 1881; pp. 106.

Many Hunterian orators of the Royal College of Surgeons, since 1814, have given us their impressions of Hunter's character and the benefit of their close study of his works, and the influence they have exercised upon the science and history of our art; but Dr. Gross is the first American author to present his brethren with an account of this distinguished man—as he describes him, “the grandest figure in the history of our profession.” The book is an enlargement of an address, which we, in common doubtless with many of our readers, perused with much pleasure and advantage, as delivered before the Philadelphia Academy of Surgery, whereof Dr. Gross is President. Short notices are accorded to Cheselden, Nourse, Douglas, Pott, Bromfield, Sharp, Warner, and Hawkins, Hunter's immediate and illustrious contemporaries and masters; and a chapter referring to his most distinguished pupils—Jenner, Abernethy, Cline, Physick, Astley Cooper, Home, Thomson, Macartney, Chevalier, Wilson and Coleman—has been added. A chronological list of Hunter's writings is inserted as an appendix. All who reverence the immortal names which we have cited, and those who care to note the landmarks of the progress of Scientific Surgery, should buy the book and read it with care and reflection. To our mind it loses none of its interest in coming from the pen of a chief among America's “Peers of Surgery” (to use Stromeyer's expression), and the author of a Surgical Treatise which the grand Apostle of Surgery, whom Dr. Gross commemorates, himself would have been proud to own. An excellent phototype, from Sharp's steel engraving of Sir Joshua Reynolds' celebrated painting of Hunter, forms the frontispiece. The book is handsomely and substantially issued, printed on good paper, in large clear type, and attractively but neatly bound.

*Minor Surgical Gynecology.* A Manual of Uterine Diagnosis and the Lesser Technicalities of Gynecological Practice. By PAUL F. MUNDE, M.D., with 300 Illustrations; pp. 380. New York: Wm. Wood & Co., 27 Great Jones Street; 1880.

Last but not least of Wood's series for 1880, this work is designed, and destined too, to take a place hitherto unoccupied in our medical literature. It comes as a repertory of help and hints to the neophyte in Gynecology, be he practitioner or student; and is no more designed to supplant the larger treatises of Thomas, Emmett, or Barnes, than are Heath or Mears on minor surgery to take the place of Eriehsen or Gross. As such we give it heartiest welcome. The author is by past experience and opportunities specially qualified to know and supply the wants of those practitioners to whom the privilege of residence in a woman's hospital or the advantages of long attendance in a gynecologic clinic has been denied. The work is divided into two parts—Gynecological Examination and Minor Gynecological Manipulation and Applications—preceded by an introduction conveying some valuable hints. Directions for verbal examination, methods and positions, together with a description and drawings of four or five of the most useful and convenient couches or tables, occupy the first 30 pages. Then follows an account of Examination without and with instruments, occupying some 85 pages and completing Part I. In all this we find much to laud, especially the thoroughness and method, and little if anything to elicit adverse criticism. Part II. treats of Catheterisation, Dilatation of Urethra, Injections into Bladder, Applications to Vagina and Cervix, Tamponade of the Vagina, Applications to Endometrium, Dilatation of the Uterus (both by stretching and cision), Curetting of the Uterine cavity, Local depletion of the Uterus, Interstitial Injections, Reposition of Displacements, Pessaries and Supporters, Artificial Impregnation, Massage and the Hypodermic Injection of Ergot. It would be manifestly impossible, within the limits of our space, to enumerate half the merits of this part, or to discuss the points which might legitimately give rise to a difference of individual opinions.

Suffice it to say that it contains a world of indispensable information for those for whom it is intended. The illustrations are so numerous as to recall an instrument maker's catalogue; but few will probably be found to quarrel with the book on that account. Some minor affections have been overlooked; but on the whole the book could hardly have been better. Perhaps the abscission of the Artificial Impregnation section would constitute an improvement.

*A Manual for the Practice of Surgery.* By THOMAS BRYANT, F.R.C.S. Philadelphia: H. C. Lea's Son & Co.

The American reprint of the third revised edition of this very excellent and highly practical work is among the recent publications, the receipt of which we have to acknowledge. The general plan of the work is the same as before; but the author, in his revision, has made some valuable additions to, as well as improvements in, the matter of the work, thus rendering it more comprehensive and correct. There is quite a considerable increase in the number of wood-cuts, illustrating the various subjects discussed, and serving an excellent purpose in their elucidation of those subjects. One subject, which does not appear to have been noticed in the English original of the work, is an illustrated description of Bigelow's Litholapaxy. This addition in itself will form a most important feature in the increased value of the work.

The fact that this work on surgery has already passed through a third edition in so short a time, ought in itself to commend it to public notice as a valuable addition to the literature of the subject. One is almost startled by the number of new works that are being constantly presented upon every conceivable subject connected with medical and surgical science. And we often cannot help wondering how such a multiplicity of literature finds patronage. The author of this work, however, may be absolved from the imputation of writing a book simply for the sake of becoming an author. He has prosecuted his work throughout in such a manner as to indicate clearly the earnest desire to

present to the profession a book in every way worthy of their perusal. He has displayed excellent judgment in disposing of each topic under consideration in the most comprehensive manner consistent with the avoidance of too great copiousness. His work is, therefore, one which should command a generous support as a student's text-book. The great objection to many of our best productions in medical and surgical literature is the fact that, while they may be invaluable as works of reference for those engaged in active practice, they contain so much matter as to be quite beyond the reach of the medical student in the comparatively limited time allotted to the regular professional course. Every student ought to have the largest possible amount of information in the most condensed shape in which it can be effectually furnished. This seems to have been the task which the author of this work set before him at the outset, and we only do him justice in saying that he has been eminently successful in its accomplishment.

In the hands of the American editor this valuable work has not suffered deterioration in any particular. In many respects the suggestions, in the shape of notes, that are appended to the various chapters, improve the character of the work. If it is quite right for American publishers to appropriate in this way the productions of the most distinguished foreign authors, we are bound to say that, in the present instance, the work has been completed in a very creditable manner.

*The Surgery, Surgical Pathology, and Surgical Anatomy of the Female Pelvic Organs.* By HENRY SAVAGE, M.D., Lond. Third Edition. Revised and greatly extended. New York: Wm. Wood & Co. 1880.

Few men have had better opportunities for the preparation of such a work as this than Dr. Savage, who was for many years the associate and colleague of Spencer Wells and Sir Wm. Ferguson, at the Samaritan Hospital for Women; and special thanks are due Wm. Wood & Co. for placing it in their Library of Standard Medical Authors, where, in so cheap a form, it comes within reach of the whole profession.



It is a most valuable work, and should be carefully read by every Gynecologist; and yet we confess to a feeling of disappointment with some parts of it. While there is much exceedingly valuable information in it, there is a good deal so very tersely put that it reads very like a dictionary. But the most serious defect, in our opinion, in view of the shortness of human life, is the total absence of an index or table of contents; and we hope that when another edition is published this serious defect will be remedied. We think the author has attempted too much for the size of the book; and the effort to compress so large an amount of useful matter in so small a space, has led to the adoption of a style which, although admirable for its brevity, is not always conducive to clearness of meaning.

There are many things in the book which we could wish were more fully realized by every aspiring Gynecologist and surgeon; and we cannot resist the temptation to place some of them before our readers, although only in the form of isolated extracts.

At page 64 he says, "the so-called whites are products of hyper-secretory *uterine glands* with debris of gland cells, \* \* \* there being no glands in the vagina, there is no such thing as vaginal leucorrhœa;" thus at once running counter to all our previous teaching on this subject.

He appears to think that carcinoma of the uterus never commences on the outside of its body, for at page 65 he asks "has there ever been seen in the uterine body true carcinomatous tissue change which did not commence at the inner surface of the uterine cavity?" and we are disposed to think he is right.

In speaking of pelvic abscess, at page 91, he advocates what we are convinced is the best practice, that is, an early opening through the vagina, and quotes a letter from Spencer Wells, in which he says "he must have tapped from twenty to thirty cases of pelvic abscess, and he could not recollect a single death. He had known several deaths where no puncture had been made." As there is a strong disposition with some practitioners to wait for a spontaneous opening, we would strongly commend these statements to the notice of our readers.

He appears still to favor the slow evacuation of the fluid when puncturing for retained menstruation; but we think Dr. Emmett has demonstrated the safety of the free incision, with antiseptic injection of the uterine cavity. At page 92 he utters a much-needed caution against the rash and reckless interference with the uterus, in regard to surgical operations, when he says, "no surgical proceeding whatever touching any part of the uterine system should be unattended by the precautions observed in operations of a grave character there or elsewhere; in certain states of the general system, unforeshadowed by any recognizable peculiarity, the most trivial operation has been followed by fatal peritonitis." He does not seem to be much in favor of intrauterine pessaries, for he says "the internal uterine stem is not only in general a failing, but a very dangerous agent." Again, he is evidently not a believer in the universality of mechanical treatment in uterine disorders, for he says "a vast majority of maladies referred to the uterus are moral, marital, or mental, and are not only rebellious to, but protracted and aggravated by instrumental treatment."

He remarks again, what we have found to be true in our limited experience, "that the majority of uterine affections, really local not constitutional, depend upon an unwholesome condition of the inner surface of the body of the uterus, and are often cured by simple dilatation of the cervix."

We cannot too strongly recommend all would-be ovariologists to read carefully his remarks on page 128, where he says "For purposes of diagnosis all that has been written is useless, nor will mere written instruction, nor instruments specially devised, bring success to the inexperienced, and it is doubtful whether ovarian surgery should be undertaken by any one who is not a surgeon in every sense of the word, without previously undergoing a sort of apprenticeship—perhaps not even then. In dealing with his first case, even the well-practised surgeon will find his hand greatly strengthened by some such preparation. The after treatment is that which not unfrequently turns the scale, and this can only be learned by taking a prolonged and active part in it."

The mere looker-on at an ovarian operation departs about as wise as when he came. Neither plates, books, nor written rules, will supply the want of judgment and experience on the part of the surgeon having to do with an operation, whereby the life of the patient is put in imminent peril by the very first incision."

We wish we could impress these thoughts with molten lead on the hearts of all who, with the most reckless indifference as to consequences, do not hesitate, without the slightest fitness, to engage in an operation, the success of which depends upon so many contingencies, and the results of which are so momentous; an operation which at times, and unexpectedly, taxes the highest skill and the most thorough preparation the world can bestow.

*A Practical Treatise on the Diseases of Women.*  
By T. GAILLARD THOMAS, M.D., 5th edition, enlarged and thoroughly revised. Philadelphia: Henry C. Lea's Son & Co. Toronto: Hart & Rawlinson, 1880.

A book which has passed through four editions will probably be held to be beyond the pale of the reviewer's influence; and the demand for a fifth may justly be regarded not only as an expression of public favour and appreciation, but also as an intimation that he who ventures to draw the bow of criticism, will find that he has sped but a pointless shaft. Fortunately our present task and purpose is one of simple commendation and enumeration of improvements. The first improvement is observed in chapter II. upon the Etiology of Uterine Disease wherein the non-recognition or neglect of injuries, such as lacerated cervix or perineum, due to parturition is very properly characterized and condemned in a few plain forcible words, not a whit too strong in view of the magnitude and prevalence of the evil. Dr. Thomas holds, and there can be no shadow of doubt about the soundness of his position, that every parturient woman should be examined by her attendant at the expiry of the ordinary term of involution, and any lesion then discovered immediately repaired. The Etiologic influence of Insufficient Food, and of Habitual Constipation, here, also, for the first time receive due recognition. The chapter on General Pathology and Treatment is also, partly

new. This is followed by an entirely new one on some of the most important therapeutic resources of gynæcology, in which are briefly noticed, Diet and Exercise, Pessaries, Precautions in Operations, Vaginal Injection, the Tampon and Means for Controlling Temperature. The Congenital and Infantile Malformations of the Female Sexual Organs are accorded a place in this edition and constitute a very desirable addition.

The chapter on the Female Perineum is rewritten and embodies, to our mind, the best description of its anatomy and uses now extant. The account of the surgical means for restoration of the perineal body has likewise been rewritten, and the method which he inculcates displays a full recognition of the maxim of Mathias Mayor "simplex sigillum veri." To the chapter on Atresia Vaginæ in the last edition we here find prefixed an account of Atresia Uteri—a welcome addition. To the article on Fistulæ a description of Uretero-uterine and Uretero-Vaginal Fistulæ has been appended.

In Chronic Cervical Endometritis extended experience confirms the author in his previously expressed approval of the ablation of the *arbor vitæ* by the cutting steel curette in obstinate cases. In the treatment of chronic corporeal endometritis he has almost wholly abandoned the use of intrauterine applications or injections above the *os internum*, substituting therefor the employment of the dull wire curette. In certain cases of chronic metritis Weir Mitchell's treatment of neurasthenia by absolute rest, massage and electricity is highly lauded, as well as the system of exercise for development of the abdominal and thoracic muscles described and advised by Geo. H. Taylor. A short reference to Martin's amputation of one lip of cervix for the promotion of involution in areolar hyperplasia has been inserted, and the account of Sim's amputation and the use of the galvano cautery omitted. The importance of a careful differentiation between granular degeneration and laceration of the cervix, as pointed out by Emmett, is here insisted upon. The account of Uterine Fungosities, as well as of laceration of the cervix is entirely new; and both chapters, although short, form a very valuable addition



to the work. The larger part of the general chapter on Displacements of the Uterus has been re-written and amended, and due credit here accorded to Cusco and Grailly Hewitt for their large and important contributions to our knowledge. The retentive power of the abdominal cavity and the vaginal promontory on which the neck rests are two new points laid stress upon among the mechanical influences tending to preserve uterine pelvic equipoise. The prognosis in prolapsus is, we are glad to say, much more favourably stated in this edition than in previous ones; and much of the treatment has been re-written or entirely altered. The anterior displacements have been considered together, as have also the posterior, instead of making a capital division between versions and flexions as heretofore; and this we consider an improvement. Several new means and methods of reposition and retention are described and figured and the practical utility of these sections, although great before, greatly enhanced. We owe to a prejudice in favour of the new pessaries. Part of the treatment of Inversio Uteri is new; and the use of an abdominal plug for counter-pressure strongly advised. We think Aveling's double-curved stem repositor deserved mention. The occasional necessity for differentiating between early pregnancy and pelvic cellulitis, as pointed out by Engelman, is adverted to. The treatment of acute pelvic peritonitis has been partly re-written, and the necessity for absolute rest, even to the interdiction of every voluntary movement, strongly insisted upon. Hildebrandt's treatment of Fibroid tumours of the uterus receives ample notice in this edition; the account of their surgical treatment has been re-written; and the author's own method of removal by the spoon-saw fully described and illustrated. The varieties of laparotomy also are noticed at length. Having reached the limits of our space we must be content with saying that much of the remainder of the book has been re-written and considerable new matter added on the topics of Cancer, Ovarian Tumours, Ovariectomy, Oöphorectomy, and Extra Uterine Gestation. In "Ovariectomy" all trocars complicated with tubing, &c., have

been abandoned; the author's own plan of operating is fully and clearly described, antiseptic precautions strongly advised, and Kibbee's Fever-cot highly extolled in the subduement of hyperpyrexia. The number of illustrations has been increased from 191 to 266. The copy it has been our pleasure to receive comes in the half-Russia binding which the Messrs. H. C. Lea's Son & Co., are making such liberal efforts to introduce for the embellishment of our library shelves. The contents of the present work are worthy of the best of binding; and we can only hope that our account of this edition will suffice to show that its author still maintains a foremost place in the van of scientific progress in this department, whilst his book continues to stand pre-eminent—in fact *facile princeps*—amongst the half dozen complete and excellent manuals of Gynecology in the world.

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### Meetings of Medical Societies.

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#### NEWCASTLE AND TRENT MEDICAL ASSOCIATION.

The Medical Association, for the Newcastle and Trent district, held its annual meeting at the Town Hall, Grafton, on the 2nd February. In the unavoidable absence of the President, Dr. Burritt, who had sent a telegram expressing regret at his inability to be present, on motion the chair was taken by Dr. Hamilton, of Port Hope.

The minutes of last meeting, held at Peterboro', were read and adopted.

Dr. McCrea, of Warkworth, sent a letter explaining that active politics in East Northumberland would prevent his being present to read a paper promised on the "Bites of Rabid Animals," and "History of a Case of Hydrophobia." He expressed his hearty interest in the welfare of the Association, and promised in future to actively support it.

After the Treasurer's report was passed, the Association adjourned for dinner at the Patterson House, where the members were guests of Dr. Halliday, of Grafton.

After dinner, officers were elected for 1881, as follows:—

President—Dr. Burritt, Peterboro'.  
Vice-President for Trent—Dr. Ruttan, Napanee.

Vice-President for Newcastle—Dr. Halliday Grafton.

General Sec.-Treasurer—Dr. Hamilton, Port Hope.

Local Secretaries—Drs. Bell, of Peterboro'; Burnett, of Cobourg; and Douglas, of Castleton.

Dr. Hamilton read his paper on "Sympathetic Ophthalmia." It was treated from a clinical standpoint, and was largely a record of experience. Notes of six cases were given. Young patients were most liable to it. The most reliable symptoms of its presence were immobility of the pupil to varying degrees of illumination, and the failing of the powers of accommodation. It was held to be commonly a sero-fibrinous inflammation affecting the iris and choroid. Treatment and general results were given, after which the mode of extension and its anatomical seat were discussed. A vote of thanks was tendered for the paper.

Some conversational discussion occurred as to pecuniary charges and infringed interests in some districts, but no conclusions were arrived at.

Dr. Halliday explained how he performed circumcision as a surgical procedure; also, how he had observed its performance as a religious rite. Others detailed their experience in performing the above operation, and that for stricture of the male urethra.

The Association then adjourned, to meet at Campbellford, on Wednesday, the 1st of June next.

#### PROVOKED TUBERCULOSIS.

M. Malassez presents an interesting note from M. Hippolyte Martin relative to the lesions determined by intra-peritoneal injections of very fine powders. The author injects into the peritoneum of rabbits some powder—of lycopodium for example, or any other very fine powder; and soon he sees produced lesions absolutely identical with tubercular lesions. The results do not vary, whatever powder is employed.—*Le Prog. Méd.*

#### Miscellaneous.

Duke Charles, of Bavaria, has lately discovered Bacteria in the choroid of two eyeballs examined by him.

Mr. Joseph Lister has been elected President of the Clinical Society of London; and Dr. Samuel Wilks of the Pathological Society.

Dr. Andrew Wood, the distinguished Edinburgh Physician, and member of the General Medical Council of Great Britain, died on the 25th of January, aged 70.

Salicylate of lime, one part to fifty of water, is highly recommended as an application to syphilitic ulcers. Its effects are described as almost magical in certain phagedenic cases.

M. Habran reported to the Medical Society of Reims a curious case, in which both parotids became swollen and painful at each menstrual period. During the nine months of pregnancy, while the menses were absent, the parotids were not affected, but immediately after delivery they again became inflamed. It is a well known fact that the mumps attack by metastasis the ovaries or the breasts, but it is seldom that the parotids are affected by sympathy with the uterine flux. A case was recently reported in which mumps complicated ovariectomy.—*La France Méd.*

RESECTION OF TWO CENTIMETRES OF SMALL INTESTINE—RECOVERY.—M. Péan not long ago removed the pylorus and a portion of the duodenum for cancer—the patient died, not from the operation, but from previous exhaustion. And now M. Kœberlé has reported a case of intestinal obstruction in a young girl, where one and a half metres of small intestine were removed, the two extremities united, and the girl recovered at the end of a month without Lister's dressing. He has also performed resection in four cases of cancer, with recovery. He also practices this operation for foreign bodies in the intestine, and to cure artificial anus.—*La France Méd.*



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# THE Canadian Journal of Medical Science.

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## Original Communications.

### MALIGNANT DISEASES.

BY GEO. WRIGHT, A.M., M.D., VICE-PRESIDENT.

(Read before the Toronto Medical Society.)

My object, Mr. President, in reading this paper is, not so much to discuss the subject of malignant diseases in all its breadth, as to give the results of my own personal experience in coming in contact with the various manifestations of these diseases, and the conclusions to which I have been led in my inquiries. To undertake an elaborate discussion of a subject so comprehensive, and involving so much mystery would be a task at once laborious and without any special profit in the present state of uncertainty among scientific men regarding almost every important feature of what is known as the cancerous dyscrasia. Despite all that has been said and written upon the subject, it is a painful reflection that malignant diseases, at whatever point in the human frame they make their appearance, seem to pursue their insidious course, with but one termination—the ultimate destruction of the lives of their victims. In these, more than in any other form of disease, the professional man is brought face to face with the unpleasant fact, how utterly helpless he is, further than to mitigate in some degree the urgency of the symptoms as they present themselves. Other forms of disease which resemble cancer in the commonly fatal results of their invasion of the system, differ, however, from it in the fact that they are occasionally so far arrested in their progress as not to destroy life always. We have frequently, for instance, seen unmistakeable

evidences of the arrest of tuberculous disease in persons who ultimately succumbed to some other affection having no relation to tuberculosis. But it is extremely doubtful in my mind if there ever was a *bona-fide* example of the arrest of any form of malignant disease. It will not be doubted that such cases are commonly found in the records of charlatanism. And, perhaps, it is not too much to say that no form of lingering disease has afforded so ample a field for the various forms of quackery as malignant diseases. From time immemorial almost, such assurances as the following have been tendered to a too-confiding public: “A certain cure for cancer.” “A painless, but effectual cure for cancer.” “Wonderful discovery! cancer cured without the use of the knife.” “Cancer drawn out by the roots by a certain and comparatively painless process.” “The surgeon defeated. The knife no longer called into requisition for the effectual cure of cancer.” “Suffering surely and certainly avoided.” Such are a few of the specimens of advertisements distributed by nostrum vendors everywhere within the limits of civilization. Indeed this may be regarded by some as one of the blessings of an advancing civilization. It is doubtful if there ever was a time in the history of the race when the public were more susceptible to the influence of imposture than at the present moment. This conviction was peculiarly strengthened in my own mind the other day during a conversation with an acquaintance, who has been a somewhat serious sufferer for sometime from chronic rheumatism. Finding no permanent relief in the ordinary channels, he was induced to try the skill of one not far from any of us and a great deal too

near to some of us, who has long been reputed to possess the miraculous gift of "*going through people*" while in a state of sleep or trance, never forgetting, I believe, that part of the individual in which his purse is most commonly found. The gentleman to whom I refer entered into a very elaborate account of the manner in which this remarkable person diagnosed his case. He told all about the body, he said, from the crown of the head to the soles of the feet, describing with marvellous accuracy the seat of disease, and the nature of it. While admitting that he had received no benefit whatever from the course of treatment to which he had been submitted, this gentleman expressed himself as very much impressed with the gift with which his newly-found doctor appeared to be endowed. The history of this notorious charlatan's success in trading upon public credulity is at once an illustration of how little success is necessary in our profession, and how easily the great mass of the people can be persuaded to accept imposture instead of science.

We often hear it remarked that the various forms of malignant disease are greatly on the increase. This may or may not be true. From my own observation I am unable to offer any positive opinion, although I am disposed to question the statement. Without doubt, there is very much more in this country than there was twenty-five years ago; but whether or not the proportion of malignant diseases to the entire population is any greater now than it was fifty years ago is a question upon which my reading or observation has led me to feel at least some degree of doubt. If the advance of medical science is accomplishing anything, it ought to be at least putting the profession in possession of those expedients by which the susceptibility to all forms of disease will be gradually diminished. My own impression is that, although once existent, the disease is no more amenable to treatment than it ever was professional knowledge of the various sanitary measures tending to lessen constitutional susceptibility has advanced very preceptibly; and that the time may yet come when to those who scrupulously follow the instructions which may be imparted, all forms of disease will be

stripped of much of the terror which they now inspire. We know, for example, or at least those who believe in the value of vaccination think they know, that this expedient has rendered one of the most loathsome and pestiferous diseases largely, if not entirely, controllable. I very much doubt if a scrupulous observance of the necessity of vaccination and its careful and effective performance would not effectually stamp out small-pox in one or two generations. We know also that an acquaintance with the sources by which contagious and infectious diseases are created and propagated has had the effect of lessening the number, as well as the virulence of epidemics. The various types of malarious disease for example, as well as those arising out of specific poisons, have had fewer outbreaks during the last twenty-five years than formerly, and the virulence of these outbreaks has been materially lessened. May we not reasonably hope that, as our knowledge of prophylactics and sanitary matters becomes more systematic and scientific, we may be able to control some diseases that now sorely perplex the profession and impair our usefulness? I am somewhat hopeful that an era in medical research may be dawning upon us that will greatly aid in lightening our burdens, and in the course of time, lessen the necessity for such a class of community as physicians and surgeons—a consummation, in the opinion of some, very devoutly to be desired.

I have been struck, in my experience with malignant disease, with the frequency with which what proved to be well-marked cases have been masked by the prominent symptoms of other forms of disease. In two cases of cancer of the kidney—the one scirrhus and the other encephaloid—that came under my own observation, this fact was strikingly illustrated in the early stages of the disease. With your permission, I will give the histories of these two cases:

Mr. M— first consulted me about the month of June, 1873. Careful inquiry into all his symptoms, previous history, &c., seemed to me to point conclusively to renal calculus as the source of trouble. The patient was a robust, well-developed man of about fifty years of age. His complaint was pain in the back over the



region of the left kidney, not distressing all the time, but simply amounting to uneasiness. He was subject, however, to occasional spasmodic attacks of the most excruciating pain, commencing in the region indicated, and extending down the track of the ureters, and accompanied with well-marked retraction of the testicle on the affected side, and very considerable nausea. The patient was reduced almost to a state of collapse on each recurrence of these spasms; and on their subsidence, he remained very much prostrated for some time. Another peculiarity was the occurrence of a copious hæmaturia after each spasmodic seizure. The patient experienced speedy relief from each seizure by the use of moderately large doses of morphia with hot fomentations, the subsequent prostration being relieved by tonics. A peculiarity of these attacks which strikes me as noteworthy, was the fact that they invariably followed some unusual exertion. The patient was what is called a "boss" carpenter in the G. T. Shops, and occasionally was tempted to make tolerably heavy lifts, with the invariable result of inducing a violent spasm of pain such as I have described. This condition of things continued until he had suffered the third attack in my hands, when, as the trouble seemed to be excited by exertion on each occasion, he was advised to take absolute rest for several weeks, and he appeared steadily to improve until I left him, as I hoped, so far convalescent as no longer to require my services. This was in January, 1874, and I saw no more of him until early in the following September, when I casually met him. His appearance indicated steady decline since my last visit. There was great loss of flesh, and his gait, through weakness and suffering in his back, was quite unsteady. During the interval that had elapsed he had been induced to try a somewhat celebrated Buffalo physician, who, I believe, undertakes to diagnose and cure disease without seeing any more of his patient than a small drop of his urine. The account, however, that this patient gave of the celebrated doctor was not of the most flattering character.

I gave my patient no great encouragement to hope for permanent improvement, as it was very apparent that his health was steadily de-

clining, but I advised further counsel in the case, and, accordingly, Dr. H. H. Wright saw him with me. Still, we were unable to seize upon any feature of the patient's case to justify a change of opinion. I saw him regularly alone from this time until the beginning of December, during which time nothing striking occurred, except that, when quiet, the attacks of hæmaturia recurred, but unaccompanied by any severe pain. Further advice was solicited, and Dr. Small saw him with me. The patient was then submitted to an equally searching examination, but with no other result than a confirmation of the former diagnosis. This poor fellow steadily but surely declined in health, and finally sank in the month of March, 1875. Until within a very short period of death there was nothing in this case to justify any other conclusion than that already reached by the gentlemen named and myself. I have since been informed by the wife of deceased that two other medical men who saw him before he fell into my hands, expressed a similar opinion regarding the nature of the disease. But about a fortnight before his death this patient's expression assumed a character which began to shake my faith in the former diagnosis. The peculiar cachectic appearance, so characteristic of most cases of malignant disease that have come under my observation became strikingly manifest. By the kindness of the friends, I was permitted to make a *post mortem*, when our former diagnosis was not very exactly verified: There was disease of the left kidney, but we didn't find any stones there. It weighed in the neighborhood of eight pounds, avoirdupois. There was not half a cubic inch of normal structure in the entire organ. It was one mass of encephaloid substance of the most typical character. The disease was altogether confined to the left kidney, the right one being normal both to touch and general appearance, but somewhat larger. None of the other organs, so far as examined, was involved in the disease.

The second case of this kind that came under my notice was equally remarkable in the way in which the disease was masked by symptoms more nearly resembling those of other forms of disease.

Mr. J—, a railway engine driver for many

years—unmarried—about forty-five years of age. Habits not of the most exemplary character. His last illness extended over a period of about nine months. During the first six months he was under treatment for what appeared to be chronic, sub-acute rheumatism. There was pain in the back in the region of the kidneys, and extending down the back of both thighs, but more acute in the left thigh. When I saw the patient first, he had been under treatment between six and seven months. His condition then was one of very considerable emaciation, the cancerous cachexia having become quite marked. When I first visited him he was in the hands of a second physician, whom we all know, and who diagnosed his disease as being connected with the liver, but what it was I am unable to say. He pronounced the case hopeless, however, and ceased to attend the patient. Another medical man was in charge when I next visited this patient, and he happened to come in during my visit; and it was then that the idea of malignant disease in some form first suggested itself. But so obscure were the symptoms, apart from the peculiar cachexia, that neither of us would undertake exactly to locate it. The man sank in a few weeks, and it was my good fortune to be permitted to make the *post mortem*.

We found, first, an enormously enlarged, fatty liver, four times the normal size as nearly as could be estimated at sight. On removing the left kidney it was found to be one mass of scirrhus, scarcely any of the normal substance remaining. The right kidney was also involved to from one-third to one half its extent. We also found that the disease involved the glandular structures along the spine as far up as the diaphragm, and I think that if the investigation had been pursued into the thorax and the spinal cord both regions, as well as the base of the brain, would have been found to be implicated, as there was marked ptosis of one eyelid for some days before dissolution. One strange anomaly in this case which, to the present hour, is utterly inexplicable to my mind, was the fact that up to the last hour, almost, of this poor fellow's illness, there was no perceptible diminution in the quantity of urine secreted. Certainly there was not the most remote

symptom of uræmic poisoning, first or last. The patient slowly sank, apparently from exhaustion pure and simple. How did this fractional part of one kidney so completely discharge the functions of two sound kidneys? I don't know. Now, the early history of this case was only obtained from the patient himself, and may not be very accurate in all particulars. I am persuaded, however, that the nature of the disease was not detected; and I am not surprised. I doubt exceedingly if any medical man would have had sufficiently reliable data upon which to establish an accurate diagnosis during the first five months of the patient's illness. Up to the last there really was nothing reliable to guide us, except the peculiar cachexia, which certainly was very marked, and which I regard as a most important diagnostic sign in most cases, although even it has failed to my own knowledge.

I have been struck with the singular fact that malignant disease may exist in an organ, and may be insidiously pursuing its steady course towards a fatal termination long before its existence is even suspected.

The following case very well illustrates this fact. Mrs. M.—first consulted me in the month of September, 1876, about four months before her death. She was about twenty-nine years of age; had been pregnant six or seven times, but had only given birth to two living children. When I first saw her she was looking pale and worn, and was complaining of a sharp pain in the left breast over the fifth rib, near to its articulation with the sternum. Careful examination of the chest failed to reveal any lung lesion to account for the symptoms from which the patient suffered. Her youngest child was twelve months old, and as she still continued to nurse him I concluded that her symptoms were neuralgic in their character and arising out of the debility from which she was suffering. I accordingly ordered tonics of quinine and iron with generous diet, and the discontinuance of nursing. I saw nothing more of her for a fortnight, when I was hastily summoned, and found her suffering most acutely from pain in the region indicated. The spasm partook largely of the hysterical type, and under valerian, and other anti-spas-



modics, yielded quite readily at first. But the patient never was entirely free from pain in the breast. Another careful examination of the chest satisfied me that there were no indications of the ordinary lung lesions. During this examination, however, my attention was directed to a distinct tumor in the region in which the patient complained of pain. It was firm, involved the fifth rib, and had all the appearance of periosteal inflammation. On inquiry from the patient, I discovered that her husband had not lived the most exemplary life; and coupling this fact with the other already indicated, that, out of six or seven pregnancies there were only two living children, I suspected specific contamination, and at once submitted the patient to the ordinary specific treatment. This was continued for a fortnight without any perceptible improvement, when I requested a consultation, and Dr. Russell saw the patient with me. We were still impressed with the idea that the trouble was specific in its origin, and the treatment was continued for another week. The patient then complained of a very disagreeable vaginal discharge for the first time. She had never, up to this time, complained of the slightest uneasiness in the region of the womb; and although there must have been some discharge previously, it had not been of sufficient consequence to cause her to direct attention to it. I made an examination *per vaginam* at once, and, to my great astonishment, discovered destructive disease of the *os*, and cervix uteri, which had already eaten away the external lip of the *os*, so that my two fingers could be easily introduced as far as the internal *os*. The edges of the ulcerated portion were irregular and sharply defined, and to the touch, were very much indurated. I again called in Dr. Russell and a careful examination was made with the speculum. The result verified my own opinion, so far as it could be verified with the naked eye, that the disease was malignant in its nature and of the character of carcinoma. The patient slowly sank from this time, and died from exhaustion in about four months after I first saw her. But a somewhat unusual, although not unparalleled occurrence was associated with this case a few days before

death. She was delivered of what appeared to be a fetus advanced to the end of about the fourth month. The patient never suspected from the first that she was pregnant, and nothing could be gathered from her history to justify the opinion of the existence of such a condition. I find, from a paper read before the Medico-Chirurgical Society of Montreal, by Dr. MacDonell, that a case occurred in his practice in which there was pregnancy coincident with scirrhus of the breast, which advanced to the full term, and the patient died during parturition.

The peculiar feature of this case, to myself, was the long existence of disease of the womb, and the extensive progress it had made before any symptoms presented to attract attention. The age of the patient was also quite unusual. I find, from the authorities at my command, that the per centage of cases of malignant disease before the age of thirty is exceedingly small.

Another case came under my notice illustrating in a most striking manner how insidiously malignant disease sometimes advances to within a few weeks of a fatal termination without the existence of a single symptom betokening malignancy. It was that of a young physician of my acquaintance, who died at the early age of thirty-three, of scirrhus of the stomach. Six weeks before death he was attending to his business, complaining of nothing but general debility. When he first sought advice from a brother practitioner, there was nothing, either in his appearance or his symptoms, to justify any other conclusion than that he was simply run down in health, and required rest and change. About three weeks before death the first alarming symptoms presented in a very suspicious-looking vomited matter. Careful examination then by the attending physicians gave decided evidences of scirrhus towards the pyloric end of the stomach, and this diagnosis was fully verified by *post-mortem* examination. The age here was also quite unusual, especially when taken with the fact that no positive evidence of hereditary taint could be made out in the family history.

Pain is not, in my experience, a very reliable guide in the diagnosis of any of the forms of

malignant disease, more particularly, however, in those cases which happen to be located in distensible parts, such as the neighborhood of the sigmoid flexure of the colon, and adjoining portion of the rectum. I saw a case illustrating very well this peculiar phase of malignant disease and possessing several points of interest to myself. The patient was a married woman, age 38, the mother of six children, the youngest being three years of age. She had suffered more or less during the last eight years of her life from habitual costiveness and periodic attacks of colic, which, so far as could be ascertained from her history, were variable in severity and duration. I did not see her until her last illness; and I confess that, to myself, the patient's recollection of the character and progress of the disease gave only a very disjointed history. She was clear, however, as to the date at which her trouble first commenced to cause her suffering, namely, eight years previous to her death. She had observed a gradual lessening of the calibre of the fecal discharges when they were consistent, and she was always costive. She suffered more or less severely, during all these years, from periodic attacks of colic, which, up to the time that I first saw her, yielded to the use of opiates and fomentations. I was first hastily called to her, and found her suffering intensely from pain all over the stomach and bowels, with a good deal of flatus. These symptoms yielded readily to the use of opiates, and in a few hours the patient was tolerably comfortable. There was still, however, a good deal of what would be called uneasiness in the left iliac region, with some tenderness on pressure. But what struck me at once, was the fact that, with all this suffering, there was little or no elevation of temperature, and absolutely no acceleration of the pulse, and hence no evidence of peritoneal trouble. After two or three days, finding that the bowels had not been moved, I ordered a full dose of castor oil; found on following day that it had no effect; ordered another full dose, no effect still; ordered injection of soap-suds, still not the slightest indication of motion; asked for a consultation, when Dr. Aikins saw the patient with me, and advised pushing remedies with a view to opening the bowels;

then gave two ounces of castor oil, with half an ounce of spirits of turpentine in emulsion, followed in three or four hours by another injection of soap-suds and an ounce of spirits of turpentine; still not the slightest indication of relaxation. Dr. H. H. Wright then saw the patient with me, and we tried everything that was considered of any use, but to no purpose. Finally, we determined, under the use of chloroform, to introduce the hand into the rectum, and try to reach the obstruction if possible. I should have stated that, by introducing the stomach tube, we were satisfied that the obstruction was somewhere in the neighborhood of the upper end of the rectum. Introduction of the hand verified this notion, and the existence of a firm tumor in the region of the sigmoid flexure of the colon. The patient sank soon after the operation, and I was permitted to make a *post mortem*. We found, at about the junction of the sigmoid flexure with the rectum, a hard tumor, about the size of the ordinary shut fist, and somewhat the same shape. On examination, the tumor was found to have had its origin in the mucous membrane of one side of the bowel, and to have steadily increased in size, until it entirely closed the passage, and had formed somewhat firm adhesions all around with the mucous membrane. Microscopical examination of specimens of the tumor proved it to be the adenoid variety of cancer.

With the exception of a slightly marked cachexia apparent in the face and on the surface of the body of this patient, there was not a solitary indication of malignant disease first or last, except, perhaps, some uneasiness in the iliac region, and the gradual narrowing of the passage, as indicated by the character of the stools from time to time. This patient began at an early age—thirty years—to be afflicted with this disease; and I was unable to obtain any circumstances in her family history pointing to marked heredity.

I believe there is no single symptom of the existence of malignant disease of greater diagnostic value than that peculiar color of the skin which is most accurately described as brassy, and which, while it resembles jaundice slightly, nevertheless differs from it very strikingly. In



nearly all the cases I have seen, this appearance was well-marked at some stage of the disease. In three or four of the cases, the histories of which I have given, it really was the only symptom to guide in the diagnosis. I should, therefore, regard it as one of the strongest indications of the existence of malignant disease where its location was at all obscure.

From my own experience I conclude that, in no form of disease is the medical man more likely to be thrown off his guard, and to be utterly disgusted with the results of medical research than in those of the malignant type. I am quite persuaded that here is a field for scientific investigation as broad as any in the whole domain of medical science, and gathering around it issues as momentous to the human family as are found to be associated with any other conceivable form of disease. I am equally certain that we have not reached, as yet, anything like a satisfactory solution of the mysteries surrounding this class of ailments. We want some one who can unravel the mystery of the origin of the cancerous dyscrasia. We have plenty of literature upon the pathology of the disease, but very little that is really valuable. After all, it is a very poor satisfaction, especially to the unfortunate patient, to be able after careful microscopical examination, to say that he died of cancer of some kind. There is a good deal of force in the remark which I once heard one of those queer characters make, whom we see retail at auction, in the market square, patent medicines of various kinds. He wound up one of those brilliant perorations, in which he discoursed most eloquently upon the marvellous powers of the remedy offered, with the significant query, "What's all the world to a man when his wife's a widow?" Well, so we may say, what's all our scientific disquisition upon the nature of the appearances of that which killed our patient going to avail so far as he or she is concerned? In short, of what avail is it at all, if it is not helping us at least to relieve those who may afterwards suffer in a similar way? That the subject of cancer has thus far completely baffled all who are engaged in medical research will not be denied, at least so far as it has helped us to a successful treatment of the

various forms of the disease. We are just as powerless, either to overcome the susceptibility to cancerous disease, or to successfully control it after it has clearly attacked the system at the present moment as we ever were. It is true, we know, or we think we know, that cancer is a local manifestation of a general or constitutional contamination, and that the products by which this systemic contamination occurs are elaborated in the blood. Beyond this we are unable to go. It is true, also, that the surgeon's knife has been pretty freely applied in some cases, with the effect of hastening the fatal issue in the vast majority of those who have submitted to the operation, and in the remainder, of only postponing it at best.

But if pathologists have already reached a rational solution of the nature of cancer, so far as to be satisfied that its development in any organ or tissue of the body is but a local manifestation of a general systemic contamination, and that the products of this contamination are originally elaborated in the blood, we may be nearer to the grand solution of the mystery than we would now be prepared to believe. If this doctrine as to the origin of these diseases be the correct one, and I do not for one moment doubt it, then why should we not reasonably hope that a means exists already, and that, in the not far distant future, it will be discovered by which the profession may control the disease as effectually at least as we now control the constitutional effects of the syphilitic poison? I doubt if there is any conceivable form of disease that afflicts humanity for which a remedy has not been provided somewhere in the wide domain of nature.

Since, therefore, we have discovered, in mercurials and iodide of potassium, an effectual means of neutralizing, if not entirely eliminating from the system the syphilitic poison, and since, also, we have found in the cinchona bark and its alkaloid, as nearly as possible, a specific for the treatment of intermittent fever, it is not unreasonable to expect that it will fall to the lot of some one, at no distant day, to present to the world a remedy by which the cancerous dyscrasia may be not only controlled, but entirely overcome; and the profession will be in a position to relieve a degree of suffering in society, such as must be personally realized in order to be accurately described.

CLINICAL LECTURE ON A CASE OF  
FROSTBITE, TORONTO GENERAL  
HOSPITAL, SESSION 1880-81.

CLINIC OF DR. THORBURN.

*History.*—J. P., aged 29, admitted Nov. 22, 1880; is a French Canadian; lives in Montreal; is a labourer; has always been healthy, of good constitution; has used liquor moderately; his family history is good.

*Present Complaint.*—Was travelling from Buffalo, N. Y., to Montreal; got as far as Hamilton by rail, when, his money being nearly exhausted, he determined to walk the remainder of the distance. Arriving at Duffin's Creek, Nov. 21st, and having no place to sleep in over night, went into a barn and lay down on some straw, his feet being towards the door. On awakening next morning he resumed his tramp, but after proceeding for a short distance, felt a severe pain in both feet. On removing his shoes and stockings, found both feet frostbitten.

On examination after his arrival at the Hospital (Nov. 22nd), the toes, and nearly as far up as the tarso-metatarsal articulation of each foot, were found affected—dark, livid in appearance.

*Treatment.*—Poultices of charcoal are ordered.

Nov. 24th.—The line of demarcation is appearing.

Nov. 29th.—There is complete separation between the living and the dead integument.

Dec. 1st.—The injury is found not to have extended beneath the skin, excepting in some of the toes.

Dec. 24th.—Amputation of the three middle toes of the left foot through the second phalangeal articulation; and of all the toes of the right foot through the metatarso-phalangeal articulation performed; the patient not being under the influence of an anæsthetic, at his request.

Dec. 30th.—Poultices of charcoal applied.

Jan. 29th.—Amputation performed of the two remaining toes of the left foot, the bones having become necrosed.

Dr. Thorburn remarked substantially as follows:—In the case now before us, we see some

of the severer effects of the application of cold to the human frame. Differing from this condition only in degree, is that common and annoying affection known as chillblain, to which I propose briefly to draw your attention in the first place. This is seen in the young frequently, and in women oftener than men. This may be accounted for by the fact that chillblains are much more liable to attack those of feeble and languid, than those of vigorous circulation. As another illustration of this truth we may remember the parts specially obnoxious to this condition, viz: the toes, fingers, nose, etc., all parts with comparatively feeble circulation.

In such patients then, and in such parts, we find, if they are exposed to the cold and heat, especially if these conditions are considerable, and more especially if the change from one to the other is rapid, a local inflammation of the skin supervening, with the following symptoms:

First, there is to be noticed a certain amount of rubefaction. The inflammatory process, if it has not been increased by irritating treatment, or unwisely stimulated by too rapid application of heat, may proceed no further than this stage. If, however, a contrary course has been pursued it may proceed to sloughing or even ulceration. This stage is thus described by the late Mr. Syme: "Ulcers of chillblain's present the appearance of a smooth, superficial excavation, with thick, white edges, and a peculiar viscid, slimy discharge."

In addition to the physical signs just mentioned, we find considerable hyperæsthesia of the part, as shown by the intolerable itchings, and often the absolute pain located there. This condition is usually increased towards evening, and is aggravated by proximity to the fire, or the application of any stimulating solutions.

*Treatment*, is local and general. Our local applications should be of a stimulating character, as tr. iodini; or cupri. sulph., grs. iij; aquæ, ʒj; or lin. saponis c. opio.

The parts should be covered to exclude the air. If ulceration has declared itself, wet lint may be applied; and when the parts are indolent in healing use this prescription:—



R Acid carbol..... ℥ij.  
 Tr. opii ..... ʒss.  
 Ol. olivæ ad..... ʒviij.  
 Sig. Apply three times a day.

If the cold to which a part has been subjected has been severe enough, or the alteration in temperature great, *frost-bite* is the result, even in persons of healthy constitution. The parts then become stiff, the skin pale or white, entirely insensible, the blood being driven from the surface to the deeper structures of the body. If the cold be exceedingly intense the part is destroyed at once, when, instead of the blood being driven to the internal organs, it will be more or less retained in the affected parts; these presenting a mottled, livid appearance. A similar appearance is seen when the ether spray is too long applied to a part, and due to the same condition, viz: blood stasis.

In regard to the constitutional effect of cold, we find there is, first, a stimulation; second, a depression. The primary excitement passes off, and a state of sleepiness ensues followed by torpor which, if not relieved, terminates sooner or later in death.

As the effect of cold is to drive the blood from the surface to the viscera and nerve centres, we find them seriously congested; death often being due to cerebral hæmorrhage, or engorgement.

The *sequelæ* of frost bite are numerous and important. Among the most interesting may be mentioned Sloughing, Ulceration, Gangrene, Pyæmia, Congestion, and Inflammation of the Lungs, Tetanus, Ulceration of the Duodenum.

In regard to the latter condition it may be noted in passing as strange that intense heat to the skin producing a 'burn, and intense cold, resulting in frost-bite, may be followed by the same result in the duodenum, viz: ulceration. Whether this can be accounted for by the vicarious action of Brunner's glands (the sudoriparous glands in both cases having been destroyed) is a point we cannot at present settle.

*Treatment of frost-bite.* One of the first and most important points in this is, to restore the circulation gradually. Too rapid re-action must be avoided. The venous circulation may be assisted by gentle friction along the course of

the veins, and by light coverings of flannel; the arterial by slight warmth, and mild local stimulation, only resorting to these measures, however, if the natural reaction seems insufficient. On the other hand, if the reaction appears too rapid, it must be kept fully under control by such means as elevation of the parts, or the use of ice water.

It is a difficult point to determine how long torpor may exist without destroying the vitality of a part. Sir John Franklin remarks that an animal may be restored to life even after the whole body has been frozen.

By the appearance of the skin for some time after a frost-bite we cannot tell how far the injury has extended; therefore, we must wait for the line of demarcation to form. By operating before this is distinctly observed, we are likely to remove healthy tissue, and may even cause supervention of pyæmia. If gangrene is evidently present, however, and the line is slow in forming, the application of a stimulating liniment will hasten the ulcerative process. The prescription given previously will, when freely applied, lessen the fætor, and reduce the tendency to a septic condition. So soon as the line is distinctly formed it may be necessary to amputate. During the whole period the strength of the patient must be kept up by all required means, and anodynes used if required. Should tetanus threaten, all dead and irritating parts must be removed.

The results in the present case fully justify the line of treatment here marked out. When first seen it seemed impossible that much of the foot could be saved. It appeared as though a Syme's, or a Pirogoff, or, at best, a Hancock's operation would be the result. But, by the expectant system, this patient has been brought, with comparative safety to his present favourable condition. Instead of being a cripple for life, as was at one time feared, and as too hasty operative interference might have ensured, he will have almost as good use of his feet as previously. The small loss of bone which he has suffered is certainly remarkable considering the nature of the injury; and to-day the parts are progressing so rapidly to complete recovery that his discharge in an excellent condition is a matter of the near future.

## Selections: Medicine.

### TREATMENT OF INDIGESTION AND HEARTBURN.

In the course of an article in the *Practitioner*, January, 1881, Dr. J. Milner Fothergill writes:—

For the purpose of whetting the appetite and thus acting reflexly upon the gastric secretion, we employ the class of agents known as bitters. To these we add hydrochloric acid. Ringer has pointed out how an alkali taken into the stomach before a meal, when the stomach is alkaline, produces a freer flow of acid afterwards. Consequently we comprehend the value of that well-known preparation indifferently termed, "Haust. Stomach," or "Mist. Mirabilis," or "Mist. Rhei et Gentian," in the various hospitals; a combination of world-wide fame. One drawback to this combination of rhubarb, gentian and soda is, that the student becomes familiar with it and its virtues, but remains ignorant of its exact composition, and so loses sight of it when he enters upon practice for himself. Such a mixture before meals, followed by ten drops of hydrochloric acid after the meal, will often make the difference betwixt imperfect digestion, producing discomfort, and digestion so perfect that it does not provoke consciousness. Or where there is much irritability in the stomach, *i. e.*, when a bare, red tongue imperfectly covered with epithelium suggests a like condition of the internal coat of the stomach, then bismuth is most soothing. The mixture of soda, bismuth, and calumba is in use for such indigestion with good results. The dietary in such a case should consist of the blandest food, milk with or without baked flour in it, beef tea with baked flour; nothing more till an improved condition of the tongue tells of a more normal condition of the stomach. In such cases a plain opium pill at bedtime often soothes the stomach very nicely. Then there are cases where imperfect digestion is accompanied by the production of fatty acids, butyric and others, which add the phenomenon of "heartburn" to the symptoms; or there may be later products formed which cause the bitter, hot taste in the mouth on awakening in

the morning or after a post-prandial nap. It is usual to treat "heartburn" by the exhibition of an alkali; but this is not good practice. In union with an alkali the offending matter is nearly as objectionable as in the form of free acid. It is much better to give a mineral acid, as the hydrochloric, or phosphoric, which breaks up the feebleness of organic acid. By such means we can aid the digestive act. Then at other times the indigestion is due to lithiasis, where the presence of uric acid impairs the efficiency of the gastric juice. In these cases all measures which do not entertain the causal relations of the dyspepsia are of little use. By the administration of potash in a bitter infusion, well diluted, taken half an hour before a meal, this element of trouble is removed. In all cases of gouty persons suffering from dyspepsia, do not forget this cause of impairment of the gastric juice.—*Med. and Surg. Reporter.*

**TENDON REFLEX.**—Senator's latest writings corroborate Tschirjew's statement that division of the spinal cord, opposite the 5th or 6th lumbar vertebra abolishes patellar tendon reflex. Division of one lateral half of the spinal cord at this level, abolishes the reflex on the corresponding side only. Division of the lateral column on one side produces the same effect. Division of the posterior cornua of the grey substance is devoid of this effect. He concludes, hence says the *London Lancet*, that in this part of the lumbar region, both sensory and motor fibres of the posterior extremities are exclusively contained in the lateral columns. Patellar tendon reflex can only be induced by one kind of stimulation, namely, mechanical shock or sudden extension by a blow.

Dr. Latham, at the Cambridge Medical Society, suggests a chemical theory for the sudden deaths from chloroform. Hoffman has shown that chloroform converts the amides into isocyanides. After a dazzling array of chemical formulæ, Dr. Latham proceeds to suggest that the blood charged with chloroform passing into the coronary arteries, decomposes some of the constituents of the muscular tissue, which, thus rendered inert, is dilated by the pressure of the venous blood, and the patient dies with a distended right ventricle.



## TABULAR STATEMENT SHOWING THE POINTS OF DIFFERENTIAL DIAGNOSIS OF CARDIAC VALVULAR LESIONS.

BY BYRON BRAMWELL, M.D., LECTURER ON MEDICINE IN EXTRA ACADEMICAL SCHOOL, EDIN.

CHARACTERS OF THE MURMUR.				EFFECTS OF THE LESION ON THE HEART AND CIRCULATION.								
Lesion.	Points of differential maximum intensity.	Rhythm.	Directions of propagation.	Left ventricle.	Left auricle.	Lungs.	Pulmonary second sound.	Right ventricle.	Tricuspid valve.	Right auricle.	Systemic venous circulation.	Arterial circulation; pulse.
Mitral stenosis.	Apex, which is normal.	Presystolic.	Downwards and inwards, to a limited extent.	Normal or small.	Dilated and hypertrophied.	Engorged lung symptoms.	Accentuated	Hypertrophied and dilated.	Towards end may be incompetent	Dilated and hypertrophied.	Engorged; dropsy; face blue, and effects of engorgement of stomach, liver, kidneys, brain, &c.	Small, weak, unequal in volume, irregular in time.
Mitral regurgitation.	Apex, which is displaced downwards and outwards.	Systolic.	Upwards and outwards to left axilla, and inferior angle of left scapula.	Hypertrophied and dilated.	Dilated and hypertrophied.	Engorged lung symptoms.	Accentuated	Hypertrophied and dilated.	Towards end may be incompetent	Dilated and hypertrophied.	Engorged; dropsy; face blue, and effects of engorgement of stomach, liver, kidneys, brain, &c.	Small, weak, and irregular in time.
Aortic stenosis.	Second right costal cartilage.	Systolic.	Upwards along course of aorta and into vessels of neck.	Hypertrophied.	Normal.	Normal.	Normal.	Normal.	Normal.	Normal.	Normal.	Small, regular, and of good strength.
Aortic regurgitation.	Second right costal cartilage, mid. sternum, lower end of sternum.	Diastolic.	Downwards to lower end of sternum.	Hypertrophied and dilated.	Normal so long as mitral valve is normal.	Normal so long as mitral valve is normal.	Normal so long as mitral valve is normal.	Normal so long as mitral valve is normal.	Normal so long as mitral valve is normal.	Normal so long as mitral valve is normal.	Normal so long as mitral valve is normal.	Jerking, visible, collapsible, and tortuous.
Tricuspid regurgitation (usually secondary)	Lower end of sternum.	Systolic.	Upwards and outwards towards right.	Normal if lesion is primary.	Normal if lesion is primary.	Normal or anæmic if lesion is primary.	Weak if lesion is primary.	Hypertrophied and dilated.	Incompetent	Dilated.	Engorged; venous pulsation in neck; dropsy, &c.	Small, weak, irregular.

## A READY METHOD FOR HOT FOMENTATIONS.—

A patient lately informed me of a method, adopted in her family for many years, to prepare flannels for hot fomentations; and, as the plan is novel to me, after thirty years' practice, and evidently very valuable, I think it may be unknown also to many others. The flannels are merely placed in the steamer of an ordinary potato steam-kettle; they quickly become thoroughly permeated by the steam, when the kettle is placed on the fire, and can be readily changed without any fear of scalded fingers during the attempt to wring them sufficiently dry, as in the ordinary method. My friend has, I understand, presented several steam-kettles, specially made for the purpose, to one of the London hospitals.—RICHARD NEALE, M.D., Lond., in *Brit. Medical Journal*.

SALICYLIC LEMONADE IN TYPHOID.—The celebrated Dr. Burggraave has made known the composition of the salicylic acid lemonade used with very good results in his wards at the Civil Hospital at Ghent. The formula of this excellent preparation is as follows:—

Salicylic acid .....	4
Tartaric acid .....	4
Simple syrup .....	75
Tinct. lemon peel .....	5
Warm water .....	920

It is taken by the patient just like ordinary lemonade. In the same establishment salicylic acid is employed for disinfecting the surgical dressings, especially the cotton wool dressings.—*Monthly Magazine*.

THE PATHOLOGY OF DIABETIC COMA.—Von Jaksch (*Prager Med. Wochenschrift*, 1880, Nos. 20 and 21) reports a case of diabetic coma in a boy of 13. The nervous symptoms supervened three weeks after the appearance of the diabetes was recognized, and the boy died in four days, with a rectal temperature of 33.3° Cent. (91.9° Fahr.) The blood examined during life showed destruction of the red blood-corpuscles, but no fat-drops. The urine gave a strong acetone reaction with ferric chloride. He also describes a case of acetonæmia in a boy who was not the subject of glycosuria, and who recovered completely after free purgation.—*British Medical Journal*.

## KOUMISS AS A SOLE ARTICLE OF DIET.—

Dr. H. Sutherland, at the Clinical Society, brought forward a case of obstinate vomiting, in which no food but koumiss was taken for eighteen months. The patient increased in weight; the daily ration was two pints of koumiss.

GREY POWDER.—According to a note by Dr. Lindo in the *Chemical News*, it appears that grey powder, after keeping for some time, is found to contain large quantities of oxide of mercury (mercuric oxide), and therefore becomes unsuitable for medicinal purposes.

An instance of serious syncope from inflation of the middle ear by Politzer's method, and of loss of hearing from a kiss upon the ear, are reported in a recent number of the *Archives of Otology*. Truly, we are becoming a nervously sensitive people.—*Alienist and Neurologist*.

## Surgery.

## NOTES ON DISLOCATIONS OF THE HIP.

BY WILLIAM T. BULL, M.D.,

Surgeon to the Chambers Street and St. Luke's Hospitals, New York.

(A paper read at the meeting of the New York Surgical Society, January 12, 1881.)

The following cases of dislocation at the hip-joint have come under my notice at the Chambers Street Hospital within the past five years. The chief interest which attaches to them is the method by which reduction was accomplished, and I shall limit myself to the consideration of this point. I should say in advance that I have been indebted wholly to Bigelow's monograph for the ideas which I have put into practice.

CASE I.—A mechanic, thirty-three years of age, while wrestling, was thrown forcibly to the ground and sustained a dislocation of the left femur, on the dorsum of the ilium, presenting all the characteristic signs of that injury. Twelve hours later ether was administered. The patient being laid on his back on the floor, the knee was flexed and the leg firmly held between my left forearm under the calf and



my right hand over the ankle. The thigh was flexed on the abdomen and rotated slightly outward, then abducted and extended. The head of the femur could be felt to pass to the edge of the acetabulum with the first three motions, but resistance was met when extension was attempted. This was the case in two trials. A third effort, with a little lifting up of the limb just before extension was made, was successful.

CASE II.—A laborer, fifty-four years of age, was hit on the back by an iron girder of the elevated railroad, while he was bending forward to pick up something from the ground. He sustained a dorsal dislocation of the right hip. Six hours later, under ether, the patient being on the floor, reduction was accomplished in one effort by flexing the thigh in the adducted position in which it lay, rotating slightly inward, then abducting as far as the perpendicular, jerking it quickly upward.

CASE III.—A laborer, thirty-six years of age, jammed between the piles of a pier by a ferry-boat, was brought to the hospital an hour later with a dorsal dislocation of the left femur. Ether was administered at once, the patient lying on the floor and the pelvis being steadied by an assistant, and the head of the bone was replaced in one effort, as in the preceding case.

CASE IV.—A deck-hand, thirty-three years of age, while sitting on the rail of a ferry-boat, was struck on the back by another boat, and his knee jammed against a post or the rail. The right hip suffered a dorsal dislocation. I saw the man four hours after the accident, and asked the house surgeon, Dr. Wilkin, to reduce it by the method which was successful in the two previous cases. His first manipulation succeeded, and reduction was completed in twelve minutes from the time the etherization was begun.

CASE V.—A workman, thirty-one years of age, fell in front of a street-car. His left knee was caught by the platform and he was pushed along in front of the car. The left femur was dislocated on the dorsum of the ilium. After two hours I tried to reduce it, under ether, by the method above mentioned. The head of the femur could be brought to the margin of the acetabulum easily, but resisted every effort to

lift it into place. I then circumducted the limb to lacerate the capsule more, and repeated the manipulation in vain. Both Dr. Wright, the house surgeon, and myself tried flexion, followed by circumduction outward and rotation outward, both with and without the "jerking up." These efforts were made both while the patient was on the floor and when on the operating table. In the latter position the second manœuvre was then practised by Dr. Murray, the junior assistant surgeon. As the head of the bone reached the margin of the acetabulum and resistance to extension was felt, the thigh was rotated alternately inward and outward while being lifted, and it slipped into place. Half an hour was consumed in these attempts.

In one of these five cases of dorsal dislocation, reduction was accomplished by flexion, circumduction outward and rotation outward with a jerk upward. One case, the last mentioned, required the further manipulation of free circumduction (to lacerate opposing capsular or muscular fibres), and a sort of rocking motion of the head on the edge of the acetabulum, which probably enabled it to slip by some portion of the capsule which had not been ruptured. In both cases the lifting up was apparently necessary in order to restore the head of the bone. This method of reduction has been frequently employed. Bigelow, who terms it the "rotation" method, especially insists on the value of this "upward jerk," both in this method and that by simple traction; and all five cases testify to the correctness of his views. In the three cases which were so easily reduced, this "upward jerk" was the prominent feature of the manipulation after flexion had been made. The thigh was flexed as it lay in a position of adduction, and carried as far outward as the perpendicular; then, on lifting it up, the head of the bone glided into place. In a sixth case the head of the bone could be felt lower down on the dorsum (in the sciatic notch).

CASE VI.—A sailor, thirty-four years of age, was jammed between two piles by a ferry-boat, while defecating. He was brought to the hospital immediately. The right limb was shortened one-half inch, the thigh lightly flexed,

adducted and rotated inward, the knee resting on the opposite one. Two efforts were made by flexion, adduction, and lifting up, but the head of the bone slid into the thyroid foramen before it was lifted. On a third effort great care was taken not to carry the limb beyond the perpendicular, and it was easily jerked into place. This case illustrates the fact noticed by several writers, that carrying the thigh too far outward in reducing the dorsal dislocation is apt to produce a thyroid dislocation.

In all these cases the after-treatment was the same. A thick layer of cotton was bound firmly about the hip with a spica-bandage, which was changed twice a day. After a week or ten days, according to the amount of tenderness, massage was practised twice a day. At the end of two or two and a half weeks movements were permitted, at first on crutches, which were laid aside at the close of the third or fourth week. No impairment of the functions of the joint followed in either case. \* \* \* \*  
—*N. Y. Medical Record.*

### PHIMOSIS AS A CAUSE OF HERNIA IN INFANTS.

BY. MR. S. OSBORN, F.R.C.S.E.

Having, in his capacity as Surgeon to the Surgical Appliance Society, to examine and apply some hundreds of trusses in the course of the year, the frequency of phimosis in combination with rupture in infants had struck the author repeatedly. The Phimosis in all these cases he was certain was the undoubted cause of the rupture, and might be thus explained: After the descent of the testicle into the scrotum has been accomplished, the vaginal process of peritoneum, through which it descended, begins to close and become converted into a fibro-cellular cord. But the testicles having but lately descended (the left coming down between the seventh and eighth month of foetal life, and the right between the eighth and ninth month), the uniting medium is but yet young, and, not being sufficiently organized, is easily broken down by any strain thrown upon it. Phimosis occasions that strain from the impediment which it offers to

the outflow of urine. For the mechanism of ordinary micturition is effected by the contraction of the muscular coats of the bladder and urethra, but in cases of obstruction to the outflow of the urine, extraordinary force is called into action, and this is effected by the contraction of the abdominal walls pressing upon the bladder, whilst the diaphragm is also at the same time in a state of tension. By this means pressure is exerted over the whole of the abdominal wall, and the apertures by which the testicles have descended to the scrotum being always the weakest points of the abdominal surface, they naturally give way under the strain thrown upon them. In other words, the child, straining to pass his water, forces the abdominal contents downwards upon the weak points at the inguinal canals, and rupture on one or both sides results. It might even be said that the canal which has been the last to close, or, in other words, that side on which the testicle was the last to descend, is the side on which the rupture usually occurs; and, knowing that the right testicle is generally the last to descend, we naturally find that hernia in infants is also met with greater frequency on this side. That the rupture occurs on the side on which the testicle was the last to descend, is only what might be expected, for the uniting medium which is effecting a closure of the canal on this side is not in so advanced a condition of organization as on the other side, where the testicle has taken its place prior to the other. It is thus easily seen how a single truss frequently produces a double rupture. The cause of the obstruction to the outflow of urine is still present in the phimosis, and one inguinal canal being guarded by the single truss, the abdomen gives way at its next weakest point, viz., the other inguinal canal, and a double rupture is the consequence. Such a result might have been prevented by early circumcision. The hernia in these cases is generally scrotal, or, if not, it soon becomes so by the wedge-like projection of the intestine; and as to whether it be congenital or infantile in variety, depends upon the amount of the funicular process of peritoneum which becomes converted into fibro-cellular tissue, or which



has been broken down by the aforesaid propulsion of intestine. The operation of circumcision, as performed upon young children, and which was done in all the cases the author had spoken of, is both easy of performance and effective in its results. No sutures are ever required; children bear the pain well; and the parts are usually well in a week or ten days. The hernia then stands every chance of being effectually cured by the application of a truss, the exciting cause having been removed; at all events, a double rupture is prevented by its early adoption. He would suggest that whenever an elongated or contracted prepuce is present in infants, the sooner circumcision is performed the better; thereby the more serious complaint of rupture will be prevented.—*London Lancet*.

**SUPRAPUBIC CYSTOTOMY.**—Petersen; in the *Arch. für. Klin. Chir.*, avoids wounding the peritoneum in this operation by taking advantage of Braune's observation, that when the bladder and rectum are distended the peritoneum on the apex of the bladder is pushed upwards so as to be easily avoided. He guards against urinary infiltration by suturing the incision in the bladder with catgut to get primary adhesion; to attain this, the bladder incision must be free and must not be bruised by forceps or calculus. Suitable conditions for the "high operation," according to Petersen, are:

1. Large hard stones.
2. Encapsuled stone or stones, lodged in sacculæ behind the prostate.
3. Hypertrophied prostate.
4. Hæmorrhoids.
5. Very fat people.
6. Tumours of the bladder.
7. Impermeable structure where it is desired to pass a fine catheter from the bladder along the ureter.

[Mr. Lister performed the suprapubic operation antiseptically twice in the same day lately at King's College.—Ed.]

**PRURITUS—BALSAM OF PERU.**—Dr. Auerbach, of Berlin, states that having, in common with so many other practitioners, found the balsam of Peru a most valuable remedy in itch, he has for some time past used it in the treatment of pruritus with the greatest success. After the first rubbing into the parts affected, great relief is obtained, and in a few days a cure results.—*Med. and Surg. Rep.*, August 14.—*Quarterly Epitome*.

## MR. OSBORN ON ANÆSTHETICS.

The annotations on *anæsthetics* given by Mr. Osborn, chloroformist to St. Thomas' Hospital, should be read and remembered by every practitioner. There are three anæsthetics in common use in the hospital: nitrous oxide, ether, and chloroform. The former is used only in operations which may be finished in a few seconds, its prolonged use being considered dangerous. Chloroform is used in children under five years of age and in old people over sixty. In the latter it is preferred to ether because it does not produce the same amount of hyperæmia of the air passages, a result which may terminate in death. Though chloroform is commonly used in children, almost any anæsthetic is well borne. With these exceptions, ether is used in all possible cases. If chloroform is to be administered, it may be preceded by a glass of brandy and water, but no alcohol of any description should be given before the administration of ether. Vomiting is more frequent after chloroform than after ether, the excessive sweetness of the former being the cause. The alternating contraction of the abdominal muscles is the principal sign of impending vomiting, and, if the anæsthesia be slightly increased, this may be subdued. Chloroform is administered on a piece of lint folded into the shape of a cone to allow of free entrance of the air. Ether is given in Clover's apparatus, and four ounces are found amply sufficient for the longest operation. Valvular disease of the heart is not considered to contra-indicate the use of ether, the heart which is most to be feared being the fatty one, which cannot be diagnosed by any auscultatory signs. Feebleness of the pulse, also, should not deter one from the administration of ether, for, although a very small amount of ether will be required to produce insensibility, the pulse will generally improve under its influence, and should it not do so the patient may generally with care be carried through the operation. In giving anæsthetics for cases operated on with the aid of Esmarch's bandage, it will never be found necessary to produce very intense anæsthesia, for the constriction of the tourniquet so deadens the limb that sensibility is blunted. Also, in patients suffering from shock the amount of the

anæsthetic required is less than in ordinary cases, on account of the nervous sensibility being already partially paralyzed. Shock may kill a patient while under the anæsthetic, death resulting, not from the effects of the anæsthetic, but solely from the shock. A lowering of the pulse has been seen to follow some of the more serious operations, and from a lowering of the pulse, on the one hand, to a fatal syncope, on the other, is only a question of degree. Death may result from cerebral hæmorrhage, the blood-vessels giving way under the increased pressure. Death may also occur from failure of the heart's action, or from asphyxia, the former being the more serious accident of the two, as the heart cannot be roused to renewed action, though, in the latter, artificial respiration may save life. When, under chloroform, there are signs of failure of the heart's action, ether may be substituted as a cardiac stimulant. In cases of threatened asphyxia, never trust solely to thrusting the lower jaw forward, but forcibly draw the tongue out of the mouth with forceps. Edema, or spasm of the glottis, or obstruction in the trachea, must be met by immediate tracheotomy, and patients have frequently been saved thereby. It is not probable that traction made upon the tongue has any effect in raising the epiglottis; therefore, if traction upon the tongue does not immediately relieve the threatened asphyxia, by allowing air to enter the lungs freely, tracheotomy must be done without delay. Finally, the conclusion of the writer is that neither ether nor any other anæsthetic is absolutely safe, and that they should always be given by one who is in the constant habit of administering them, and who will give his sole attention to the work of managing them.—*New York Medical Journal*.

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EPISTAXIS—NASAL INJECTIONS.—Thurston depends upon the well-known fact that liquid injected into one nostril returns by the other, and in cases of epistaxis, introduces the nozzle of a syringe into the nostril not bleeding, and holds it firmly. A stream of cold water, thrown in thus, washes out all the clots from the bleeding nostril, and often arrests the bleeding. If not efficient for this purpose, he uses a dilute solution of perchloride of iron.—*St. Louis Cour. Med., July*.—*Quarterly Epitome*.

## THE INFLUENCE OF THE WILL IN THE TREATMENT OF SPINAL DEFORMITIES.

In the usual acts of volition, the mental process is entirely concerned with the results obtained, and takes no heed of the action of individual muscles. In raising a cup to the lips, the attention is fixed on the elevation of the hand by the flexion of the elbow, not on the contraction of the biceps, brachialis anticus, and other flexor muscles of that joint. But it is well known that the will can exert control not only over groups of muscles acting together, but upon individual muscles, and, by practice, can cause contraction of muscles formerly not under the direct control of it. Thus, by practice, the biceps can be contracted alone without any other of the flexors of the elbow-joint, each one of the facial muscles can be separately contracted to show its individual action, the scalp can be moved to and fro, or one or other of the muscles of the soft palate can be put into use as desired, and thus its individual action verified. For the most part, this power of contracting single muscles independently of the common purposive movements of the body, is in abeyance, and cultivated by a few as a study, and by others as an amusement. But it was reserved for a Dr. Kjoelstad, of Christiania, to make use of it as a curative agent in certain cases of deformity of the spine, especially lateral curvature. Dr. Tiedemann has developed the treatment still further, and Dr. Roth has recently called attention to it in this country. It is stated that by making patients with lateral curvature of the spine examine their deformity, by the aid of a reflecting-glass, a contraction of the muscles, which are weakened, and which by their relaxation permit or even cause the deformity, can be excited by the will. By practice, these contractions can be made of longer duration, increased in strength, and excited independently of the aid of vision, so that by a single act of volition these weakened muscles can be set in action, and the deformity corrected or lessened. It is easy to see how the cure of this affection can be thus expedited and aided—for it is not suggested that it is able alone to cope with severe deformities—



and it indicates a direction in which those who have such cases under treatment may derive help. It is in strengthening the weakened structures and exciting to tonic contraction the relaxed muscles that the true cure of scoliosis lies. Spinal supports may assist by rendering such a return of the normal condition more easy of attainment; but alone they are not calculated to prove curative, and there is ample experience to show that when trusted to for more than accessory aid, they not only disappoint, but may even exaggerate the evil they are designed to benefit.—*London Lancet*.

**VARICOCELE.**—In a paper on this subject read before the Clinical Society of London, Mr. Pearce Gould suggested a new view of the pathology of this affection. He asserted that neither the greater length of the spermatic vein on the left side, nor its passage beneath the sigmoid flexure, nor the mode of its entrance into the renal vein, satisfactorily explained the more frequent occurrence of varicocele on that side; and suggested that the use of the valve usually present at its mouth, was to convert the direct aperture into an oblique one; and that the blood current in the renal vein exerted an aspiratory effect on that in the spermatic. He pointed out that varicocele is a disease of early life, most often before puberty; that it may remain stationary or undergo spontaneous cure; that the veins are not subject to thinning of their walls or spontaneous rupture; and that the affection is not produced by the common cause of other varices, but was a true venous hypertrophy. He advocated the operation for radical cure. In all these points Mr. Bryant concurred.

**SPERMATIC CRYSTALS.**—From an examination of the seminal vesicles and prostatic fluid from fifty bodies, Furbinger has determined that the "spermatic crystals," described by Botcher, occur exclusively in the prostatic secretion. They appear to be identical with Charcot's crystals (discovered by Robin) which, Schreiner says, consist in a phosphate of a new organic base. Their clinical significance is an abundant secretion from the prostatic glands.—*London Lancet*.

**EXCISION OF STOMACH.**—On the 29th of January, Billroth, of Vienna, excised (*London Lancet*) six inches of greater curvature of stomach, including pylorus, for infiltrating carcinoma. Incessant and uncontrollable vomiting determined Billroth to operate. The operation lasted one hour and a half. There were extensive adhesions to omentum and colon. Fifty silk sutures were used to unite the duodenum to the remaining portion of stomach. In a week the sutures were removed from external wound which had united without reaction. The patient was able to take tea, coffee and light nourishment. In 1879, Péan performed the same operation; catgut sutures were employed, and the patient died on the 4th day.

**NEW METHOD FOR PRODUCING PHARYNGEAL ANÆSTHESIA.**—Rossbach produces insensibility of the pharynx by cutting off the conduction of the sensory nerves which supply it. These are given off from the laryngeal nerve superficially just below the knobbed end of the large horn of the hyoid bone. A subcutaneous injection of morphia at this point produces anæsthesia, or the ether spray applied simultaneously to both sides has the same effect, in from one to two minutes.—*Phila. Med. Times*.

**EPISTAXIS—PERCHL. IRON SPRAY.**—A spray of perchloride of iron in epistaxis is recommended as often avoiding the necessity of plugging the nares.—*Med. Record, July 24.—Quarterly Epitome*.

William Rutherford Sanders, M.D., Edin., who succeeded the younger Begbie as the Chief Consultant Physician of "the grey metropolis of the North," died of apoplexy on the 18th of February, in the fifty-seventh year of his age.

**HAMILTON MEDICAL AND SURGICAL SOCIETY.**—Officers elected for this year. President, Dr. A. Woolverton; Vice-President, Dr. H. Ridley; Secretary-Treasurer, Dr. E. G. Kittson.

## Midwifery.

### ANOMALOUS PYREXIA IN WOMEN.

BY J. MILNER FOTHERGILL, M.D.

What may be disease, or, rather the indications of disease in a woman of lymphatic temperament, may be a matter of little or no moment in a woman of distinctly nervous temperament. In this latter class of persons, I venture to suspect considerable perturbations occur quite commonly; and without exciting alarm until the clinical thermometer is brought into play, and the consternation is established. But the remarks of Austin Flint on the perturbations of temperature causing needless alarm, in his recent work on "Clinical Medicine," should be read and carefully thought over by every man who takes upon himself to wield a clinical thermometer. Beyond noting a distinct rise, the practitioner should keep his head cool, and look about him keenly for the cause of the rise. If the patient is a woman, the more likely the perturbation is to be merely neurotic. If the nervous system is highly developed, the suspicion is strengthened. But before deciding that a pyrexia is of organic origin, a careful examination should be made to discover, if possible, the local cause; if none be found, then the next duty is to scrutinize the features of the malady to see if they bear any familiar resemblance to the well-known specific pyrexia; if no such family likeness can be traced, then examine the stranger still more minutely to see that it is not a "solar pyrexia," or one of those nondescript entities just beginning to be discriminated and classed. And above all, bear in mind the perturbations of the catamenial week, and track down the catamenia, and see if the malady will not "fit" in time to the menstrual week; and so diagnose the ailment by its chronological associations. When hunted down and discovered to be really a neurosis, an exaggeration of the normal perturbations set up by the catamenia, the prognosis becomes cleared; just as the removal of dark clouds reveals a sunlit sky. The nervous nature recognized, the treatment becomes simplified; and not only that, but it is effective. Such plan of looking at an anomalous pyrexia in women

would often save much needless alarm and apprehension amongst the patient's friends; perhaps, also, some possible loss of credit to the practitioner; and even gain some credit to the watchful physician who does not trip into the pitfall before him, but sees his way in "devious places."—*Excerpt from The American Journal of Obstetrics.*

### OVARIAN PEDICLE LIGATURE EXTRUDED THROUGH THE URETHRA.

At a meeting of the New York Obstetrical Society, Dr. Thomas spoke of a case that had lately come under his notice, in which a silk pedicle ligature, left in the abdomen after ovariectomy, had subsequently ulcerated through the bladder. Lodging in the urethra, it caused some impediment to urination, and on this account the patient was examined and the ligature was removed. The silk was entirely unaltered. At a previous meeting, Dr. T. A. Emmet showed the remnant of a silk ligature which he had applied to an ovarian pedicle and dropped, and which had been discharged through a sinus in the cicatrix six months afterwards. He advocated the return to silver wire ligatures as being more likely to become encapsulated.—*N. Y. Med. Journal.*

**INVERSION OF THE URETHRA.**—The late president of the N. Y. Obst. Soc., W. T. Lusk, at a late meeting, made brief mention of a case of this sort which he had been invited to see by Dr. Janeway. Examination showed a bright red tumour projecting apparently from the urethral orifice, but which proved on examination to be really a complete inversion of the urethra itself. The patient was etherized and the mucous membrane was replaced. When the patient was last heard from, some four or five days after the operation, it was still in place. Dr. Mundé related the history of a similar case, which he had seen about a year before at Mount Sinai Hospital. The inverted urethra was mistaken for an epithelioma, and preparations were made to remove it by means of the galvanic cautery; but a few days later, when the patient was placed upon the table for operation, it was found that the tumour had disappeared. Evidently the oedematous mucous membrane had sloughed off.—*N. Y. Med. Jour.—Quarterly Epitome.*



**DANGERS OF TENTS.**—At a meeting of the N. Y. Obstetrical Society, Dr. T. A. Emmett said (*N. Y. Medical Journal*) that in his experience dangerous consequences were especially liable to follow the use of tents in nervous and hysterical subjects. He referred to a case that he had reported last winter, in which trouble did not occur until the seventh day. The patient should never be allowed to get out of bed until the next day after the removal of the tent. In spite of all precautions, he always felt, when about to use a tent, that he was endangering his patient's life.

**TRIPLETS WITH TEETH.**—Dr. Love, in the *North Carolina Medical Journal*, reports a case of triplets—two girls and a boy—born with teeth: 1st, girl, 4½ lbs., two middle upper incisors and two upper canines; 2nd, girl, 5 lbs., two middle upper incisors and left upper canine; 3rd, boy, 6½ lbs., four upper incisors and two upper canines, nearly through. They each lived five hours. The mother was 45 years of age, this was her second pregnancy.

### Translations.

#### ASPHYXIA OF THE NEW-BORN.

Dr. Gayard, in *La France Médicale*, relates a case in which the method of LeBon succeeded in restoring life, after all other means had been tried for an hour and a half and failed. LeBon's method is based upon the fact that infants' blood does not coagulate so soon as an adult's, and that often, it is want of caloric, as well as of oxygen, that is required to re-animate the child. So he places the infant in a basin of water at 40°-50°c. (104°-122°). In this case, at the end of about 30 seconds, a strong inspiration was made and in five minutes all was well.

#### HYPERTROPHY OF THE NERVOUS CELLS OF THE PROTUBERANTIAL REGION IN PARALYSIS AGITANS.

M. Luys has specially studied the lesions of the nerve cells of the medulla, the protuberance and cerebral and cerebellar peduncles in subjects with paralysis agitans: he finds the

volume of these cells to be double that of healthy cells. M. Luys thinks that this cellular hypertrophy is in relation with the functional superactivity of the elements in this disease. This fact would be analogous to the exaggerated development of the cells of the cerebral cortex in cases of expansive delirium and to the swelling of the gray substance of the cord in cases of medullary irritation. (Charcot.)—*L'Union Méd.*

#### TREATMENT OF THE VOMITING OF PHTHISIS.—(HANOT)

In phthisis in the gastralgic forms of vomiting, the application to the pit of the stomach of a flying blister, or the hypodermic injection of morphine in the same region, often produces very favourable results. Prof. Peter administers before each meal a drop of laudanum in a small spoonful of water, in order to diminish the susceptibility of stomachal mucous membrane, without determining general effects. Dr. N. Gueneau de Mussy also recommends a short while before meals the use of a pill containing one centigramme of ext. belladonna. Dr. Pidoux combats the vomiting of the tubercular by means of nux vomica, which has the advantage of stimulating the stomachal tonicity in place of stupifying it, and of remedying the anorexia so common in the course of pulmonary phthisis.—*L'Union Méd.*

#### IPECAC DURING LABOUR.

In a note published by the *New York Medical Journal* Dr. Garrigue considers ipecac as a powerful stimulant of the uterine contractions. It is to this action that it owes its property of arresting metrorrhagias. Thus ipecac appears indicated in cases of rigidity of the os when the woman is worn out by prolonged and completely inefficacious pains. It is given in the dose of 12 centigrammes.

As an oxytocic, ipecac, according to Garrigue, is superior to ergot of rye; in fact the contractions that it provokes are comparable to those of natural labour, they are produced at regular intervals and after periods of rest. In a great number of cases of rigidity of the os with insufficient dilatation when each pain excites and

greatly exhausts the woman, ipecac brings in a short time calm and strength; the os dilates, the expulsive contractions become regular and powerful, and the labour is promptly terminated.—*La France Méd.*

#### RESORCINE.

Of the employment of resorcine, M. Dujardin Beaumetz says, at the Hospital Medical Society, I am at present experimenting with a new product: Résorcine, a substance taken from assafoetida. It is a crystallized body, white, without odour, soluble in all proportions. It prevents the fermentation of all albuminoid substances, milk, urine, &c.

The Germans make use of it principally for dressings. There are many points of resemblance between résorcine, carbolic and salicylic acids.

It may be used topically in ulcerations of all kinds: thus I have dressed cancers with it, and mucous patches, and have obtained satisfactory results. In diphtheria it may replace carbolic acid, as it has no disagreeable odour. For the local affections of the stomach it may be useful.

Résorcine is toxic. When the dose surpasses 6 or 7 grammes, then the toxic results obtained are the same as with carbolic acid.

I believe then that this body may give good results as an antiseptic in surgery; but in medicine where it may be given in doses of 2 grammes without danger, its efficacy is not yet demonstrated.—*La France Méd.*

#### INHIBITORY INFLUENCE OF THE NERVOUS SYSTEM UPON NUTRITIVE CHANGES.

Influence of the nervous system upon the changes between the tissues and the blood. M. Brown Sequard recalls the power that the central nervous system possesses, under the influence of certain irritations, of arresting more or less suddenly the activity of nutrition in the different tissues and organs. Almost all parts of the cerebro-spinal centre, as well as the sensitive and sensorial nerves, are capable of producing, like the beak of the *calamus scriptorius*, the arrest of these changes. The inhibitory power of the nutritive changes that the bulb or

the cervical cord possesses is so considerable that it suffices to produce the arrest of these changes to drag upon these parts by suddenly flexing the head upon the thorax. Then the venous blood becomes red and the temperature of the animal falls, and as there is at the same time apnoea, it is necessary to conclude that the cause which determines the arrest of the changes between the tissues and the blood is endowed with great power. In an animal in which the dorsal cord has been cut through and which is submitted to irritation of the bulb or to other irritations of the encephalon or cervical cord, capable of producing an arrest of the changes between the blood and the tissues, we find the existence of this arrest everywhere, except in the parts that receive their nervous supply from that portion of the cord which is severed from the encephalon. Consequently, it is certain that it is by a nervous influence, proceeding from the encephalon or the cervical cord and acting on the tissues, that the inhibitions of the nutritive changes in this experiment take place.—*L'Union Méd.*

#### ALTERATIONS OF A DEAD FÆTUS IN THE UTERINE CAVITY.

The question raised at the Academy of Medicine, by M. Guéniot, was not solved, but, as usual the discussion was turned aside from the end originally in view. Thus, yesterday, the influence of knots in the cord upon the life of the fœtus was much less a question than the alterations of a dead fœtus in the uterine cavity. M. Blot produced at the tribune, citations from two authors, Rainard and Martin, showing that the fœtus in the uterine cavity is mummified or macerated, but that it never putrifies, unless the ovum have been broken, and the air have penetrated into it. He showed on the other hand that the dead fœtus exercised no morbid influence on the health of the mother, even when it remained in the uterine cavity for a year or a year and a half. He recalls those curious facts in which the fœtus is dissolved in the amniotic liquid and in which in an old ovum devoid of solid parts, some hairs or a morsel of cord form the sole vestiges of a vanished fœtus. Otherwise these were but current ideas which M. Blot re-



called solely to oppose them to the contrary affirmations of M. Colin. (d'Alfort.)

M. Depaul in support of the same facts, presented the cadaver of a macerated fœtus, which had remained in the uterine cavity for seventeen days without the mother's health failing. The learned professor at the same time recalled the symptoms by means of which we may recognize the death of the fœtus. In addition to the absence of the movements felt by the mother or by the physician and of the cessation of the heart sounds, M. Depaul exposed other symptoms, perhaps less known; after the death, the breasts of the mother become tense and painful for some days, then the milk flows and the breasts become soft. On the other hand the belly diminishes on account of the resorption of a part of the amniotic liquid. We find on palpation a softer and less resistant mass than usual.—*La France Méd.*

### Correspondence.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

SIR,—The correct pronunciation of the medical terms in common use is a matter of very great importance to the reputation of the practitioner, not merely as a physician, but as a man of education. We, in Canada, are daily and hourly making mistakes in our Latin and Greek quantities; mistakes for which an English schoolboy would be birched, and which bring no great credit upon us when we go abroad.

We can defend a man, who wilfully and with malice prepense, calls the abdomen, "the abdōmen," the umbilicus "the umbilīcus," and who pronounces "vertigo," "porrigo," and "origo," with a short penultimate. I have heard a professor tell his class to "call it 'porrigo,' short you know;" and another professor, I heard, in a public address, speak of something or another being the "fons et origo mali." Yet there are some who would have capital punishment abolished.

We who speak the English language are an ungrateful set. For professional use we take words from Greek and Latin, take them body and bones, and alter them in such a way as to destroy their individuality. For example, take

the word "trachea," it is common in America to hear "trăchĕa." We took the Latinized word for τρᾶχηα (the nominative feminine of the adjective τρᾶχύς); we deprived it of its diphthong, and then added insult to injury, some of us going about calling it "trăchĕa." Again, "ureter" is a purely Greek word, οὐρητήρ,—observe the long penultimate—but who has not heard it called the "urĕter."

How is it that the public always speak of "eczĕma" and "enĕma." They must have heard their doctors using these terms. Those doctors ought to know that ἔκζεμα is ἔκζεμα, and not ἔκζημα, and that ἔνυμα is ἔνυμα and not ἔρHEMA.

Anatomy furnishes us with "massĕter" instead of "massĕter," (μασσητήρ more correctly μασητήρ) "trachĕlo-mastoid" for "trachĕlo-mastoid." But, after all, these slips are not so very dreadful. Think of "cathĕter," "confum," and "vesico-vaginal fistula." I am happy in expressing my belief that these last atrocities are perpetrated over the border only.

Many who read these lines may exclaim, "What pedantic rubbish!" I can tell them, though, of many Canadian graduates who found themselves checked, harrassed and confused by the many corrections they met with at the membership examinations of the Royal College of Surgeons. When candidates speak of the "saphĕnous vein," of "ĕpŭlis," and of "hæmatemĕsis," examiners with delicate classical sensibilities have found it necessary to set them right as they go.

There are many words which, by usage long existing, have been incorrectly written as well as pronounced. "Hæmorrhage" is commonly written "hemorrhage," and pronounced with its first syllable short. "Carōtid" should be "carōtid," (καρωτίδες). "Jugular" is "jŭgular," not "jŭgular," (jŭgŭlum); "fōrāmen" should have a long penultimate, and should not be pronounced as if it had two "m's" in it.

What right have we to drop the diphthong in "perincĕum" and write "perineum"? Why "aneurism" and not "aneurysm," (ἀνεῦρυσμα)?

Now, Mr. Editor, my growl must cease, and this letter must be brought to a close with the hope that friends may rush to the rescue of our old cronies, the dead languages, and that our cherished Latin and Greek terms may be defended from the murderous attacks of the barbarians.

I remain, sir,

Your obedient servant,

DIGAMMA.

Feb. 22nd, 1881.

THE CANADIAN  
*Journal of Medical Science,*

A Monthly Journal of Medical Science, Criticism,  
 and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, APRIL, 1881.

EXAMINATIONS ONTARIO MEDICAL  
 COUNCIL.

As our readers will observe in the minutes of the Executive Committee, all those candidates who, at the Matriculation Examination held in August last, reached an aggregate of 45 per cent. of the whole number of marks required, are now passed as regular Matriculants, such Matriculation to date from the time of said Examination. This is a happy thing for the "dead men" thus so suddenly and so strangely resurrected. To be plucked for six long weary months, and then to be passed is, to say the least of it, somewhat unusual. The subject, when viewed in all its bearings, becomes a little mixed, too, because the resolution of the Executive, by its retrogressive action, declares that they were passed at the time they were plucked. In this case we may slightly change the words of the poet, and say with reference to the longed-for "pass," "thou art so far and yet so near." It's such an easy way of doing it, too; so simple when you know how. Perhaps we should congratulate this Province upon having a medical examining system so elastic in its nature; and a governing body so full of inventive genius as to enable them to dexterously skip over, jump through, or crawl under any difficulties which may beset their path.

We see by another resolution that the Committee has referred the whole subject of the Matriculation to the Medical Council. At the last meeting of this august body, it was decided, after mature deliberation, to adopt the

Intermediate High School Examination, simply choosing Latin as the optional subject which the candidate must take; and again, after what we must call very immature deliberation, it was decided to make certain changes, which have rendered the scheme entirely impracticable. Altogether, the question is now in a hopeless muddle, which "no fellow can understand." We hope the Council at its next meeting will either adopt the Intermediate as first proposed, or return to the old system, and fix a certain standard which will be fair and just, without going to an extreme in the direction of being too high or too low. Anything reasonable will be better than the present condition of perplexing uncertainty.

As will be seen by advertisement in this issue, the Matriculation Examination is to be held at the Collegiate Institute, Toronto, on the 19th of April. The Professional Examinations are to commence April 5th, and Primary April 11th. The names of the Examining Board are a guarantee that the Examinations will be conducted in a thoroughly efficient and practical manner. We are glad to find that Dr. Sullivan will not be prevented, by any technical objection, from acting as Examiner in Anatomy. By a rule of the Council, no one is allowed to examine in any subject upon which he lectures in any of the schools. In the practical subjects, this limits the choice very materially, as it is absurd to suppose that an ordinary graduate of several years' standing, who has not been engaged in teaching, is fit to conduct a thoroughly practical examination in such a subject as Anatomy. Under the circumstances, it is, therefore, fortunate that the Executive Committee has not been compelled to substitute any other for Dr. Sullivan, who, by mistake, was said in the announcement of the Kingston Medical College, to be Lecturer on Surgical Anatomy as well as Surgery. Dr. Sullivan is well known to be thoroughly conversant with this subject, and in every respect well fitted for the position of Examiner. We may also say to the trembling candidate who dreads his severity, that he is in every sense the student's friend; and although he endeavours honestly and faithfully to keep up the standard in the profession, and sometimes gives



what are considered rather difficult questions, yet he is always anxious to give full credit for all answers, and, when in doubt about determining their value, is always inclined to favour the candidate.

### EXECUTIVE COMMITTEE, ONTARIO MEDICAL COUNCIL.

A meeting of the Executive Committee was held in Toronto, on Tuesday, March 1st, 1881.

Present: Drs. Bergin, Macdonald, Husband, Allison, Burns, and Edwards.

Dr. Menzie was introduced by Dr. Moslyn, and requested to be allowed up for his Primary and Final Examination in the spring of 1881, he being a Graduate of McGill College. Granted on condition that Dr. Menzie pay the fees for all examinations, and produce his certificate of Matriculation in McGill in 1874.

Mr. D. Wallace was granted permission to go up for his Final Examination in 1881, he having spent the first year, after matriculating, in a doctor's office, and taking his lectures after this.

After a long discussion on the question of the Matriculation Examination, it was moved by Dr. Allison, seconded by Dr. Edwards, "that the subject of the Matriculation Examination be referred to the Council." Carried.

With reference to the matter of Dr. Sullivan being lecturer in Surgical Anatomy, Dr. Lavell, being present, was asked to explain to the Committee regarding the R.C.P. and S., of Kingston's announcement. Dr. Lavell stated that Dr. Sullivan did not lecture on Surgical Anatomy, and that the statement in the announcement was a mistake. The Committee accepted Dr. Lavell's statement.

The petition for Dr. Sullivan's removal was not granted.

On considering the petition of Mr. John A. Macdonald, it was resolved that all the Primary Students, who passed on three or more subjects at the Examination of 1880, be allowed credit for such subjects.

A letter regarding Dr. Sinclair was now read, when it was moved by Dr. Husband, seconded by Dr. Edwards, that Dr. Sinclair be allowed to come up for the Professional Exam-

inations without matriculating, he having been in active practice for the last twelve years. Carried.

A communication from Dr. J. D. Wilson was now read, asking to be allowed to take his Primary Examination this spring, he having passed all the subjects for matriculation in 1878, excepting one subject which he succeeded in passing in 1880. Granted.

A communication was read from Mr. W. F. Mills, asking to have the 9 months course in Ann Arbor accepted as a 6 months' course in Ontario. Granted.

Moved by Dr. Allison, seconded by Dr. Burns, that those gentlemen who, in the Matriculation Examination of August, 1880, made 45 per cent. of the aggregate marks, be permitted to register as Matriculated Students from that date, and that the Registrar notify the gentlemen affected by this resolution. Carried.

Moved by Dr. Burns and carried, that the Registrar inform the Candidates who passed on any subject at the late Matriculation, August, 1880, that such subject is allowed them at the coming examination.

The written Examinations at Kingston are to be arranged for and conducted by Dr. Lavell of Kingston as heretofore.

### UNIVERSITY SENATE ELECTIONS.

The following circular has been issued to the Graduates:—

TORONTO, MARCH 17, 1881.

Owing to the rule providing for the annual retirement of three members of the Senate, the Reverend Dr. MacNish, Mr. T. W. Taylor and Dr. McFarlane are this year the retiring members.

Mr. Taylor and Dr. McFarlane are candidates for re-election. Dr. MacNish, owing to his inability to attend meetings of the Senate, has declined to be again a candidate, and has expressed his desire for the election in his stead of Mr. W. G. Falconbridge, formerly Registrar of the University.

Mr. Taylor, Dr. McFarlane and Mr. Falconbridge, therefore, request your support and vote at the coming election, assuring you that their

best attention will be paid to University interests should they be elected.

(Signed), T. W. TAYLOR,  
L. MCFARLANE,  
W. G. FALCONBRIDGE.

Such a ticket as this requires no comment. We hope our friends will, without exception, give it their hearty support. At the time of our last issue it was supposed that a vacancy was created in the Senate by the election of Mr. Mulock to the Vice-Chancellorship. The name of Mr. McQueston, of Hamilton, was mentioned in connection with this supposed vacancy, and the above-named gentlemen had agreed to support him. When it was found that this vacancy would not occur until next year, Mr. McQueston's friends in Hamilton urged him to remain in the field, and yielding to their solicitations he assumed the peculiar position of opposing the men who actually brought his name before the public as a candidate. Having put on his armour, and gone out on the war-path, he no doubt felt that it would be rather irksome to retire ingloriously to his wigwam, and remain in peaceful retirement for a whole year. Having the highest personal regard for this gentleman, we can only regret that he was unable to restrain his martial ardour; as a fair certainty of election next year would be much preferable, in our opinion, to a fourth place this year, even with all the glory thrown in.

**DIVISION OF LABOUR.**—This is becoming fashionable of late in Toronto as well as other places. In the latest case coming under our notice, a celebrated clairvoyant is looking after the internal economy, putting in some new apparatus (a pair of lungs at present, we believe), while a surgeon is treating hæmorrhoids in the same patient. The clairvoyant in giving the surgeon simply the anus to manipulate, is allowing him rather a short hold.

**PUBLIC HEALTH.**—Dr. Brouse's speech in the Senate on "Public Health" has been published *in extenso* in the *Canada Health Journal* for March. Copies can be had on application to the editor, Dr. Edward Playter, Toronto.

The name of Mr. T. H. Monk has been mentioned in connection with the proposed system of Registration of Diseases. He became well and favourably known to the profession, throughout the Province, last year, by his vigorous efforts to inaugurate and carry out such a system. Dr. Edward Playter, well known as the indefatigable editor of the sanitary journal for some years, is also mentioned as a candidate for the post.

*The American Edition of Bryant's Surgery.*—In the notice, in our last issue, of the American reprint of the third English edition of this well-known work on surgery, we inadvertently omitted to give due credit to Dr. John B. Roberts, Lecturer on Anatomy and Surgery in the Philadelphia School of Anatomy, for the labour, which was no sinecure, expended in issuing and improving this American Edition.

Dr. George Smith, practising for the last seven years in Sebringville, has removed to Galt. We bespeak him much success in his new sphere of labour.

### Book Notices.

*Hemiopia.* By WM. DICKINSON, M.D., St. Louis; 1131 Washington Av. (Reprint from the *Alienist and Neurologist*.)

*Remarks on Syphilis.* By WALTER COLES, M.D., St. Louis. (Reprint from *Trans. St. Louis Medical Society*.)

*Objective Points in the Treatment of Phthisis.* By WM. PORTER, A.M., M.D., of St. Louis. (Reprint from *Medical Herald*.)

*The Development of the Osseous Callus.* By HENRY O. MARCY, A.M., M.D., Cambridge, Mass. (Reprint from *Transactions of American Medical Association*.)

*Litotriessia Rapida in una Sola Seduta.* Un'Ernia Inguinale Ovarica Simulante Strozamento Intestinale. Raffo Dott. Costantino. (Reprint from *La Sperimentale*.)



*Clinical Reports confirming the Results of the Experimental Researches on the Physiological and Therapeutic Actions of the Phosphate of Lime.* By L. DUSART: Paris: 8 Rue Vivienne, 1880.

*Colorado for Invalids.* By S. EDWIN SOLLY, M.R.C.S., Eng.; L.S.A., Lond.

An interesting account of the climate of Colorado, written for the laity, with a brief description of the sanitary aspects of Denver, Colorado Springs, Manitou, Pueblo, and Cañon City.

*The Popular Science Monthly.* Conducted by E. L. and W. J. YOUMANS. D. Appleton & Co., 1, 3 and 5 Bond St., New York.

Every physician's table should bear this valuable monthly, which we believe to be one of the most interesting and instructive of the periodicals now published, and one which is destined to play a large part in the mental development of the laity of this country.

*Transactions of the American Ophthalmological Society. Sixteenth Annual Meeting.* Newport, 1880. Published by the Society, 1880.

The papers and discussions embodied in this beautifully executed volume—of interest mainly to specialists—afford fresh evidence of the industry and scientific spirit of the members of this society.

*The Illustrated Scientific News.* Published by MUNN & Co., 37 Park Row, New York.

We would direct the attention of our readers to this new illustrated paper, designed to portray the various novelties in science and the useful arts. The March No. contains engravings of Capt. Eads's proposed ship railway across the Isthmus, an account of the manufacture of paper hangings, and much other interesting and instructive matter.

*Ophthalmic and Otic Memoranda.* By D. B. St. John Roosa, M.D., and Edward T. Ely, M.D., New York. Revised edition. New York: W. Wood & Co., 1880.

This little book is an excellent example of *multum in parvo*, and is deserving of the favour which calls for a new and revised edition. The

design and scope of the work may be gained from the statement of the authors, who, by the way, are above the suspicion of encouraging superficiality: "It is rather a dictionary of ophthalmic and otic science than a text book, and gives only a bare outline of the subject of which it treats; and it is never to be recommended as a substitute for the larger works."

*Food for the Invalid; the Convalescent; the Dyspeptic; and the Gouty.* By J. MILNER FOTHERGILL, M.D., and HORATIO C. WOOD, M.D. New York: Macmillan & Co. Toronto: Willing & Williamson.

This may be called a scientific cookery book. The introduction, written by Dr. Fothergill, consists of some practical remarks on the Chemistry and Physiology of the digestive system, and useful hints on the proper modes of feeding the invalid in bed, the child in the nursery, the convalescent, the dyspeptic, and the gouty. The remainder of the work consists of some three hundred recipes; the greater number of which are initialed for the convenience of the reader: I, standing for invalid; C, for convalescent; D, for dyspeptic; G, for gouty, etc. The work will be found very useful and convenient as a guide in the dietetic treatment of disease.

*A Manual of Pathological Histology.* By V. CORNIL, Ass't. Prof., Faculty of Medicine of Paris, and L. RANVIER, Prof. in the Collège de France. Translated with notes and additions by E. O. SHAKESPEARE, M.A., M.D., and J. HENRY C. SIMES, M.D., of Philadelphia. With 360 Illustrations on wood. Philadelphia: Henry C. Lea. 1880.

Another excellent manual which bids fair to become a formidable rival of that which has hitherto been the American Student's chief Authority and Reference Book, Rindfleisch's *Pathological Histology*. Published in France in 1869, the original text has, of course, fallen greatly behind the times; but the careful and conscientious revision and additions of the American editors—so well known in this country as sound and advanced pathologists—have brought the subject matter as fully as possible up to date. The book is constructed on a somewhat similar plan to Rindfleisch's work, but presents some new and commendable

features. It is divided into three parts: Part I. dealing with General Pathological Anatomy, and being preceded by a chapter on Normal Histology—cells and normal tissues; and one on General Principles—alterations of cells and tissues. The subjects of Inflammation and Tumours are then discussed. To the last-named section a valuable addition has been made by the insertion of a highly excellent "Classification and Condensed Description of Tumours, arranged on Virchow's Histogenetic basis from the lectures of Prof. Tyson, of the University of Pennsylvania, by Dr. H. F. Formad."

Part II. treats of Diseases of Organs and Tissues, and each section is preceded by an account of the normal histology of the organ or tissue under consideration.

Part III. is subdivided into five sections, in which the Normal and Pathological Histology of the Respiratory, Digestive, Hæmopoietic and Genito-urinary apparatuses and of the Skin are successively and lucidly described. As a general criticism, and the limits of our space preclude all detail, we may say that the volume reflects very faithfully the present state of scientific knowledge in this interesting and most important department of medical research. A copious and useful Bibliography completes the work. The illustrations, as a rule are good, and most of them will be familiar to the reader being culled chiefly from the well-known textbooks of Rindfleisch, Green, Gray, Carpenter, etc. To student and practitioner alike, the work may be safely commended as a recent and reliable exponent of the facts of Pathological Histology hitherto acquired to science.

*A Treatise on Diphtheria.* By A. JACOBI, M.D. New York: Wm. Wood & Co., 1880. Toronto: Willing & Williamson.

The author of this treatise is well known in medical literature, and has embodied his views on diphtheria in communications to various journals at different periods. This work embraces his latest views of the disease in question.

The book is divided into seven chapters devoted to the consideration of the History, Etiology, Anatomical Appearances, Diagnosis

Treatment, etc. At the conclusion of each chapter is a summary of its contents, a novel and convenient feature of the work.

Dr. Jacobi is not an adherent of the Bacteria theory of the cause of diphtheria. He considers the evidence in favour of that theory to be insufficient for its establishment. His opinion on the identity of true croup and laryngeal diphtheria is, we think, the correct view; and we shall be pleased when it is generally recognized that the word croup indicates merely the sign of stenosis of the larynx arising from whatever cause.

The period of incubation is two days or may be more. The contagium shows a disposition to rise, so that when the disease makes its appearance in a house it is well to remove the patient at once to the top room of the building.

The author rejects Certe's view of the nature of diphtheritic paralysis, and considers that it is, at times, central, and at others peripheral; and that its most prominent characteristic is the uncertain course it may pursue.

Potassium chlorate is used frequently in small doses for its beneficial action upon the accompanying stomatitis and pharyngitis. He deprecates the employment of large doses of the drug for fear of producing severe and even fatal nephritis. Chloride of iron is recommended, also in small doses frequently repeated. As soon as the pulse begins to be small and frequent, stimulants must be exhibited in large and frequent doses. He says the danger is in giving too little. The local treatment of the disease consists in frequent washings of the throat and mouth with disinfectant washes. He disapproves of canterisation unless it can be thoroughly done, and of forcible removal of the membrane. Steam, if it does not interfere with the proper oxygenation of the patient, is a source of relief. When suffocation threatens tracheotomy is to be performed. The paralysis often requires time and rest only; but if severe, or threatens life by implicating the respiratory muscles, strychnia hypodermically acts promptly and efficiently.

Most of the remedies introduced by Bacteria enthusiasts as Sodium Benzoate, have not withstood the test of experience in his hands.

The book is nicely gotten up in clear type, good paper, attractive binding, and has a copious index. It is the completest scientific work upon the subject which has yet appeared.



*A Treatise on the Principles and Practice of Medicine.* By Prof. AUSTIN FLINT, M.D. Fifth Edition. Revised and largely re-written. Pp. 1,150. Philadelphia: Henry C. Lea's, Son & Co.; Toronto: Hart & Rawlinson. 1881.

A mere mention usually suffices for the 5th edition of a work; but within the last 7 or 8 years, since the appearance of the 4th edition of this favourite text-book, the progress of medical science has been such that its subject matter had fallen greatly behind the times, and other works on practice, such as Bristowe, had begun to supplant it in the esteem of the American Student and Practitioner. It is with unfeigned pleasure, therefore, we are able to announce that this last edition is once more abreast of the subject and the times.

The first seven chapters dealing with general Pathology, have been entirely re-written, and emanate from the pen of Dr. William K. Welch, Lecturer on Pathological Histology in the Bellevue Hospital Medical College. Dr. Welch has also contributed in great part the description of the anatomical characters of the various diseases in other portions of the book. Of these we can honestly affirm that even if, as a recent reviewer has alleged, they represent chiefly Cohnheim's and Weigert's views, we believe them to be eminently sound, and Dr. Welch's exposition, on the whole, a careful and intelligible account of the, for the present, best founded and most acceptable doctrines of Pathology. We hope in the next edition to find some reference to the clinical characteristics of splenic fever and the other anthracoid diseases.

The chapter on Etiology has been much improved by the insertion of a modern definition of contagion and infection, a clear account of *Contagium Vivum* and of parasites in general. In describing the two modes of dying, our author employs the term apnoea (and etymologically correctly so) in place of asphyxia, hence perpetuating the confusion arising from the adoption of a special signification for apnoea by some physiologists. In the practical portion of the work, much effete matter has been expunged and more than an equivalent of new inserted. It would be a hopeless task to endeavour, within the space at our disposal, to narrate the changes which have been made

throughout the book. Suffice it to say that a most thorough revision has been effected in all parts; many additions have been made in the sections on Phthisis, Cardiac, Hepatic and Renal Diseases; and the affections of the Nervous System re-arranged and described in accordance with the great advances made of late years in this department. The Therapeutics, too, of each affection have been carefully brought up to the level of the most recent experience, so far as corroborated and confirmed by extended observations. In point of fact the fifth edition is a new work; and once again worthy to assume a position, honourable at once to its author and his country, in the front rank of Treatises on the Principles and Practice of Medicine. A greatly improved and copious index adds greatly to the utility of the volume. The copy we have perused is issued in the half-Russia binding, now being popularized by the enterprising Messrs. Lea's Son & Co., and constitutes a volume attractive alike in its appearance, odour, and intrinsic excellence.

*A Practical Treatise on Tumours of the Mammary Gland: Embracing their Histology, Pathology, Diagnosis and Treatment.* By SAMUEL W. GROSS, A.M., M.D. New York: D. Appleton & Co., 1, 3 & 5 Bond Street, 1880. Pp. 246.

Dr. Gross's present work does for tumours of the mamma what Mr. Henry Trentham Butlin's late lectures at the College of Surgeons accomplished for the testicle, whilst at the same time dealing with tumours of that gland other than sarcoma and carcinoma. It certainly fills, and in our humble judgment most satisfactorily so, a long standing lacuna in this portion of surgical literature; and brings within the reach of the dullest amongst us a clear and intelligible account of the present state of our knowledge in this department of pathology, thus affording him the means of acquiring a reason for the faith that is in him as a practical surgeon. To be sure Billroth's great treatise is now extant, and like all his writings is thorough, comprehensive and exhaustive; but most of our readers will prefer a work in our own vernacular, and to such we may say that Gross's present book is without a rival, much less a

peer, in the English language. The author's object has been to apply a close and accurate study of the minute structure, general pathology and life-history of mammary tumours to their differential diagnosis and rational treatment. In this laudable emprise the verdict of our judgment is that he has been eminently successful. His deductions have been based upon a careful analysis of 65 cases of cysts, and 902 neoplasms "the nature of which has been confirmed by the microscope, and more than  $\frac{1}{4}$ th of which are original." The first chapter treats of classification and relative frequency. The author enters a strong protest against the loose application of the term adenoma, as a consequence of the early writings of Lebert and Birkett; and pronounces true adenomata to be amongst the rarest of neoplasms. His classification consists in a primary division into Neoplasms and Cysts. The neoplasms comprise: 1. (a) Tumours, etc., representing the mature connective tissues, and called typical, including Fibroma, Myxoma, Lipoma and Chondroma; (b) those representing embryonic connective tissue, and called atypical, the sarcomata. 2. Neoplasms proceeding from the secreting elements and composed of Epithelium. Of these adenoma is the typical, and carcinoma the atypical representative. 3. Those derived from higher structures: Angioma and Neuroma. It will be hence observed that the terms typical and atypical are here employed as synonymous respectively with the clinical expressions benign and malignant.

With reference to frequency of occurrence, it appears that cysts constitute one out of every 54 tumours; and that among the solid neoplasms 83 per cent. are carcinomatous and 17 per cent. non-carcinomatous. Amongst the non-carcinomatous  $48\frac{1}{2}$  per cent. are fibromata,  $47\frac{3}{4}$  per cent. sarcomata, 3 per cent. adenomata, and 1 per cent. myxomata.

Chapter II. discusses the evolution and transformation of mammary tumours, very fairly stating and criticising the different views of the opposing schools of pathologists, including those of Creighton, and finally states his own belief in the origin of adenoma and carcinoma from the lacteal glands (Waldeyer) and that of the histoid or simple neoplasms

from the connective tissue. As to etiology, our author shows that the non-carcinomatous tumours result from traumatism in 11.94 per cent. of all cases, and the carcinomatous in 11.70 per cent. His figures, too, lend no support to the current view that the development of these tumours is influenced by the state of the organs of reproduction. Dr. Gross is no believer in the constitutional derivation of cancerous tumours. With regard to the influence or significance of precedent eczema or psoriasis of the nipple, the author's figures show them to have been precursors in 1.44 per cent. of the non-carcinomatous, and in 1.03 per cent. of the carcinomatous growths. With reference to patient's age, the author holds that "structural perfection of the mamma renders it most obnoxious to fibroma, sarcoma and adenoma, while atrophy or decay predisposes it to myxoma and carcinoma."

An excellent account of the anatomy of the connective tissue neoplasms occupies Chapter IV. Then follow in successive chapters, Fibroma, Sarcoma, Myxoma, Adenoma, and Carcinoma. The chapter on Sarcoma is particularly good. A Sarcoma occurring before the age of 20 is stated to be a spindle-cell tumour in  $\frac{7}{8}$ ths of all cases. Local elevation of temperature is regarded as characteristic of telangiectatic and rapidly proliferating growths. Pain was noted in 63.4 per cent. Sarcoma is shown to be less infectious locally, but more infectious systemically, than Carcinoma. In Carcinoma, our author expresses the conviction that infection takes place along the perivascular lymph sheaths; but admits that the regional dissemination may occur along the lymph vessels as shown by Waldeyer and Langhaus. The elective seats of cancer are said to be the upper and outer quadrant of the breast, and the immediate neighbourhood of the nipple. Dimpling or pitting of the skin is regarded as one of the earliest and most reliable signs of cancer. Retraction of the nipple (not due simply to bulging of the breast around it) is spoken of as a sign of inestimable value. We should like to have heard the author's opinion, when speaking of infection of adjacent tissues, of the frequency and value of enlargement of the upper end of the humerus. Cur-



ously enough the liver appears to be liable to secondary infection in one-third more of the cases than the lungs, in which the secondary deposit of sarcoma so frequently occurs. When left to itself the average duration of Breast Cancer is stated at 27.1 months, while in cases submitted to operation the average duration was 39 months. Operation thus appearing to add 12 months to the patient's life. Permanent recovery after the operation may be expected according to the tables furnished in 9.05 per cent. of all cases. "In point of malignity, although its course is essentially chronic, atrophying scirrhus is the most pernicious of the tumours of the breast."

Cysts are discussed in Chapter X., which is followed by a chapter on the Diagnosis of Tumours, consisting essentially in a re-statement and tabulation of differential points enumerated in preceding sections. One point insisted on is, we think, not generally sufficiently regarded in making a diagnosis, viz:—the recumbent position of the patient and the exposure with absolute freedom of both glands. This chapter we are sure cannot be consulted too often by the practical surgeon. With regard to treatment, although Duplay's method of compression is alluded to, the knife is regarded as the one necessary and potent remedy, an opinion in which we believe most practical surgeons will concur. For the mitigation of local pain in cancer, the application of a solution of 15 grains of acetate of lead in an ounce of water is commended. In the removal of cancerous growths no half-measures are advised. Complete extirpation with clearing out of the axilla is the only hope. Antiseptic precautions are discarded as unnecessary, and our author has no experience of their use, but quotes Oldekop's results as being unfavourable to them. (8.7 per cent. deaths with ordinary dressings, 9.1 per cent. with antiseptics). Some short statistics of tumours of the male breast conclude the work.

As is most meet, the book is dedicated to Samuel D. Gross, the author's father, whom we all honour with the honour due unto him for the uses we have had of him.

It is excellently got up, in clear large type, singularly free from blemishes and illustrated with 29 engravings.

## Meetings of Medical Societies.

### TORONTO MEDICAL SOCIETY.

Meeting of 24th February, the President (Dr. Covernton) in the chair. Dr. Jas. Ross, jr., was elected a member. Dr. Oldright mentioned a number of cases in which severe pulmonary symptoms developed suddenly, the urine proving to be albuminous. Such cases may be associated with pregnancy, and it is always desirable to test the urine during gestation, in order to be forewarned of and avert the untoward consequences which may ensue. Dr. Covernton also referred to a case presenting a similar train of symptoms lately under his observation, and not pregnant. Dr. R. A. Reeve directed the attention of the Society to a new dilator of the pupil, prepared synthetically and denominated Hydrobromate of Homatropin (or Oxytoleuytropin). It is used in a  $\frac{1}{2}$  to 2 per cent. solution, and acts rapidly, the paralysis being complete in about 20 minutes and passing off in 12 to 48 hours; whereas that from Atropin lasted a week or ten days, and that from Duboisia 5 or 6 days. Moreover, the new remedy is non-poisonous. A general discussion followed upon mydriatics, and especially upon the double action of pilocarpin, which was attributed to its containing two alkaloids—jaborin and pilocarpin—the former of which dilated the pupil, whilst the latter determined its contraction. Dr. Davidson then read a paper upon Fractures of the Shaft of the Femur. After a few preliminary remarks, he referred to the predisposing causes of fracture, mentioning Syphilis, Rickets, Cancer, Caries, Atrophy, &c., and recounted a case of multiple fractures from slight causes which had fallen under his observation. Displacements of the upper fragment occur readily, but are difficult of reduction and retention. They may be due to the action of muscles attached to the upper fragment itself and drawing it upwards; or the lower fragment, being acted upon by the muscles attached to it, may shove the upper fragment forward. An angular displacement outwards also commonly exists. In the lower third of the bone, fractures are usually transverse. The treatment advocated was by long

splints and weights and pulley; short splints encircling the thigh, the writer thought, are not often required, and may stand in the way of examination of the position of the fragments. In children and other restless patients, a long splint on each side of the body may be required. A  $\frac{1}{4}$ -inch shortening he considered a good result. As a permanent dressing after removal of the long splint, he recommended the gum and chalk bandage, and described the details of its application. Dr. Oldright pointed out the necessity of having the pelvis properly placed, avoiding all obliquity, before proceeding to make measurements of the lower extremities, and illustrated by diagrams the errors most likely to arise. Dr. Workman considered insanity a predisposing cause of fracture, and said that insane patients frequently sustained fractures and gave no evidence of suffering pain therefrom. Dr. Burns referred to Jarvis P. Wight's measurements, and reiterated the admonition that many men had normally uneven legs. Dr. Covernton mentioned a case where a medical man was mulcted by an intelligent jury in a large sum on account of half an inch shortening after fracture, notwithstanding that the abbreviation made the two limbs of equal length. Dr. Cameron held that the majority of fractures had no predisposing cause, but were simply matters of mechanical violence. He had little faith in measurements, and thought that two observers scarcely ever made exactly the same measurements. He employed the short, light splints around the thigh, in addition to the long. There could be no doubt but that insanity and other nervous diseases, such as Locomotor-Ataxy, Disseminated Sclerosis, &c., sometimes gave rise to a fragility of the bones. Had Dr. Davidson observed the Hyarthrosis of the knee, so much insisted upon by French surgeons in Fracture of the Shaft? After some further remarks by other members, Dr. Davidson in reply closed the discussion.

Meeting of 10th March, Dr. Lett in the chair, until President's arrival. Drs. Cassidy, Jas. Baldwin, and McCullough were proposed as members. Dr. Davidson exhibited a portion of the right ventricle of the heart of a little girl, 9 years of age, who, while convalescent

from Scarlatina, died suddenly. The autopsy discovered tricuspid vegetations, and thrombosis of left middle cerebral artery near its bifurcation. Dr. Cameron showed specimens from an old woman, 80 years of age, who died suddenly. Up to seven weeks before her death she had been constantly at work and made no complaint. About this time, in the midst of her work, she would complain of headache and lie down for a few minutes; suffered from constipation and became jaundiced. In two or three weeks she began to keep the bed, and said that she was getting old, but had no complaint beyond the constipation. The icterus became intensified. On the morning of her death she fell out of bed, but got in again without assistance; and at the time of Dr. Cameron's visit, two hours later, had full use of her limbs and was perfectly intelligent. About an hour afterwards she suddenly became unconscious, and remained so for six hours, when she died. The autopsy revealed (20 hours after death) a large, left inguinal hernia, chiefly omental, and containing a large proportion of the greater omentum, so that the transverse colon was drawn down in the shape of a V almost to the neck of the sac, where it contained a cancerous nodule. The invaginated portion of omentum was dotted with similar nodules of the size of a pea, as was also the anterior wall of the sac, which likewise presented numerous spots of pigmentation. The posterior wall of the sac was devoid of both. At the neck of the sac the omentum had lost all its fat. The left lobe of the liver was almost entirely converted into a cancerous mass, in which were inextricably involved the gall, bladder, and pancreas. The spleen was diffluent; the stomach dilated; the uterus was somewhat enlarged (multipara); the right ovary completely atrophied, the left partially so. The right *par ovarium* contained two clear pea-sized cysts; the left one similar and one the size of a walnut. The aortic valves were partly ossified; the lungs presented small lunged emphysema; the brain cortex presented on the right side in the posterior cerebral region, a large, firm blood clot, as big as the palm of a large hand, which presented two distinct portions, the upper and central part—two-



thirds of the whole—being firm and decolourised ; whilst the peripheral third was soft and black. The brain substance was considerably flattened, but apparently not softened much. Dr. Cameron related the details of another case of apoplexy occurring in a man aged 70, in his usual health up to the moment of the attack, which occurred about 7 a. m., and began with vomiting and immediate loss of consciousness. The breathing was slightly stertorous ; pupils neither contracted nor dilated, nor unequal, nor responsive to light ; unconsciousness insuperable ; face drawn or fallen slightly to right, the head being inclined to right side. The right arm rigid and twitching ; the left flaccid ; pulse, 118 ; respirations, 26 ; death in 5 hours. The autopsy showed senile kidney, calcareous plates in aortic valves, and diffuse hæmorrhage at the base of brain, a very soft clot compressing the left pons, filling up left sylvian fissure, and distending left lateral ventricle. The vessels at the base were extremely calcareous, and had been cleanly dissected out, like rigid tubes, by the effusion. The dura-mater was almost universally adherent to the skull ; and the brain substance, which was very soft, was considerably lacerated in removal. He also reported the clinical details of a third case of apoplexy, which had occurred to him that week. Dr. Robinson mentioned a case of atropin poisoning in a child, two years of age, who had sucked the cork of a bottle containing the sulphate of atropia. The usual symptoms were presented. Two minims of Tinct. Opii were given every hour, and the child recovered.

Dr. Carroll related a case of aconite poisoning in a child, to whom 30 minims of tinct. aconiti had been given by mistake at 7 a. m., and no symptoms appeared until a second dose had been given at 10, when vomiting, accompanied by alarming prostration, occurred. Large doses of ammonia were administered, and recovery ensued.

Dr. Cameron reported a case of attempted poisoning by acetate of lead. A half-pound was purchased, and a large, but unknown, quantity taken dry with suicidal intent. An emetic of sulphate of copper was administered, and later sulphate of magnesia in milk. No

symptoms followed, except pretty severe cramps on the following day, easily relieved by opium.

Dr. Burns read a paper upon Some New Remedies, in which he discussed Grindelia Robusta, Yerba Santa and Rheuma, Chaulmoogra Oil, Eucalyptus Globulus, Nitro Glycerine, Tonga, &c. His own experience had not been favourable to the use of most of them. Dr. Oldright enquired if there were any limit to the dose of Grindelia Robusta. He had used Chaulmoogra Oil in rheumatic gout with benefit. Dr. Sheard had seen it employed beneficially in lupus of the face, and considered it useful in other tubercular affections, such as leprosy. Drs. McPhedran, Reeve, and others took part in the discussion, and Dr. Burns replied.

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### Miscellaneous.

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Dr. Canquoin, the inventor of the *pâte de Canquoin*, died at Dijon, in his eighty-sixth year.

Dr. Peter David Handyside, F.R.S.E., Examiner and Teacher of Anatomy at the College of Surgeons, Edinburgh, died on the 21st of February, at his residence in Lansdowne Crescent, Edinburgh.

We have had the "divine Sarah" Bernhardt in Toronto. A correspondent of the *Chicago Medical Journal and Examiner* says, that when she was in New York, "the principal interest, in a medical point of view, was the fact, that she was so thin, that when she took a pill she looked as if she was pregnant."

INDIA RUBBER AND GUTTA PERCHA INSTRUMENTS, that have become brittle by exposure to sunlight, as in shop windows, may, it is said, be rendered again flexible by immersion for a few minutes to a half hour in a mixture of one part of liquor ammoniæ, with two parts of water.—*Med. Press and Circ. New Remedies.*

LONGEVITY OF MEDICAL MEN.—The calendars of the Royal Colleges of Physicians and Surgeons, London, give some rare examples of longevity amongst their fellows and members,

viz.:—Arch. Billing, F.R.C.P., Park Lane, 90; Joseph Hurlock, F.R.C.P., Brighton, 88; Sir Thos. Watson, Bart., F.R.S., 88; Alex. Tweedie, F.R.S., F.R.C.P., 86; J. A. Wilson, F.R.C.P., Holmwood, 85; Bisset Hawkins, F.R.S., F.R.C.P., 84; Sir James Alderson, F.R.S., late Pres. Royal College Physicians, 80; Chris. J. R. Allatt, F.R.C.P., of Dover, 80; Sir Geo. Burrows, Bart., F.R.S., late Pres. Royal College Physicians, 79; James Muscroft, F.R.C.S., of Pontefract, 95; T. M. Greenhow, F.R.C.S., of Leeds, 90; Robert Taylor, F.R.C.S., of Brighton, 91; James Moncrieff Arnott, F.R.S., late Pres. R. Coll. Surgeons, 87; J. F. South, F.R.C.S., of Blackheath, 84; Cæsar H. Hawkins, F.R.S., Sergeant-Surgeon to the Queen, 83; James Luke, F.R.S., F.R.C.S., of London Hospital, 83; Robt. McCormick, R.N., F.R.C.S., 83; this last named gentleman accompanied Sir Edward Parry, as Assist. Surgeon in H. M.'s ship *Hecla*, in the attempt to reach the north pole in 1827.—*The Daily Telegraph*.

**TREATMENT OF ECZEMA.**—M. Mook insists much, and with reason, upon the general treatment—the treatment modificatory of the diathesis on which the eczema always depends. Arsenic in herpetics, alkalies in arthritics, iodine and sulphur in the scrofulous should be placed in the front rank. As external treatment, he gives baths of half an hour's duration, at from 25 to 30 degrees (77°-86°F.); however, eczema rubrum is benefited by permanent baths. In this case Hébra gives baths, which continue from 8 to 10 days; arthritics, however, do not take well to baths; it is preferable in them to dust the diseased parts with powders. In the second period, characterized by rupture of the vesicles and formation of crusts, he employs cataplasms of cooked potato starch; lotions with an infusion of camomile or a decoction of clecampane root, and caoutchouc to envelop the diseased parts. In the third period, when the surface attacked by eczema becomes dry and shiny, he ceases all emollient applications. He employs starch powder or lycopodium, with one-third of subnitrate of bismuth added, or the oxide of bismuth or zinc. When scales form he employs

cataplasms or leaves of caoutchouc to make them fall; then, when there is no more redness, he employs pomades. In the dry forms with pityriasis desquamation, M. Vidal employs the following glycerole:—Glycerole of starch, 20 grammes; tartaric acid, 1 gramme. In impetiginous eczema, M. Vidal employs the following weak cadic glycerole:—Glycerole of starch, 30 grammes; pure oil of cade, 5 grammes. In arthritics he uses this pomade:—Glycerole of starch, 30 grammes; carmine, 2 grammes; calomel—à lavapeur, 1 gramme. Mr. Lallier employs this mixture:—Distilled water, or marsh mallow water, 100 grammes; neutral glycerine, 10 grammes; or oil of cade, diluted with half or third of oil of sweet almonds. Erasmus Wilson considers the undermentioned pomade as a veritable specific in eczema:—Purified lard, 100 grammes; benzoin, powdered, 20 grammes. Triturate together, and afterwards melt at a gentle heat for twenty-four hours in a closed jar, and pass through muslin; then add from 3 to 5 grammes of oxide of zinc to 30 grammes of the pomade. If there is at the same time some itching, we may add a soothing substance, such as camphor, 20 centigrammes, or cherry laurel water in the dose of 3 grammes for 30 of pomade. M. Hardy employs in his pomades the fresh cerate or cold cream, and as active matter the mercurial preparations—as calomel, 20 to 30 centigrammes; the red oxide; the sublimate; the protonitrate, in the dose of 5 to 10 grammes to 30 grammes of the excipient. M. Vidal for some time has used simple plaster (litharge and lard) in the third period. In chronic eczema oil of cade is employed, either pure or mixed with equal parts of glycerole of starch; oil of cade, on account of its bad odour, may be replaced by birch oil (*oleum rusci*). In the scrofulous one often sees produced, after the lengthened employment of humid topical remedies, a profound dermatitis, against which the following emulsion has been successfully prescribed:—Balsam of gurgun, lime water, partes aequales. For eczema with thick scales, with thickening of the skin, we employ a solution of nitrate of silver, or a solution of potassa mixed with water in diverse proportions, according to the extent, intensity, and antiquity of the affection. M. Vidal, in these torpid cases, makes use of sparadrap and diachylon, which, well applied and covered with wadding and a bandage, produces a species of compression and occlusion.—*La France Méd.*



# THE Canadian Journal of Medical Science.

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TORONTO, MAY, 1881.

## Original Communications.

### CLINICAL LECTURE ON IDIOPATHIC OR PERNICIOUS ANÆMIA.\*

BY WILLIAM OSLER, M.D., M.R.C.P., LOND.,  
*Professor of the Institutes of Medicine, McGill College.*

(Delivered at the Montreal General Hospital in the Summer  
Session Course, April 14th).

Gentlemen,—The patient before you offers an example of that interesting disease described by Addison, in 1855, as “Idiopathic” Anæmia. Biermer, in 1872, thought he had discovered a new affection, and gave it the title of “Progressive Pernicious Anæmia.” Lebert gave to it the name of “Essential,” and you will find it described under one of these three terms. Here, in Montreal, we have been made familiar with it by the labours of Dr. Howard, your Professor of Medicine, whose paper, before the International Medical Congress, held at Philadelphia in 1876, was one of the earliest and most important of the recent contributions to the subject. Owing to his kindness, and that of several of my colleagues, I have had opportunities of investigating certain points in connection with the pathology of the disease, particularly with reference to the state of the blood and the bone marrow.†

The history of the case is as follows:—

Thomas W—, aged 47, a well-built Englishman, was admitted under the care of Dr. Ross,

\* Reported by Mr. T. W. Duncan, and revised by Dr. Osler.

† *Canada Medical and Surgical Journal*, March, 1877; *Transactions of the Canada Medical Association*, 1877; *Centralblatt, f. d. Medicin Wissenschaften*. Nos. 15 and 28, 1877, Berlin; *Centralblatt, f. d. Medicin Wissenschaften*. No. 26, 1878.

on January 19th, transferred to my charge on the 1st of April. He was a bricklayer by trade, but served for twelve years in the army, and was through the Crimean War. For the past two years he has been a baggage-man at the Railway station. He has always enjoyed good health, has never had ague, though he resided for some time in a malarial district. He is a married man, has four children; has not had any special domestic or mental trouble. Up to August, 1877, he enjoyed good health; but about this time he began to feel weak and lost colour. He fainted on several occasions, and had attacks of bleeding at the nose. In January, 1878, he entered the hospital, and remained three months—his symptoms being anæmia, without any recognizable cause, weakness, swelling of the ankles and retinal hæmorrhages. He improved very much, and in a couple of months after leaving the Hospital, was able to work, though pale and weak. Through the years 1879 and 80, he followed his occupation, but never regained his former strength or colour. There appear to have been slight digestive troubles as he has not been able to eat meat.

In August last his wife was confined and was very ill afterwards. Attendance upon her and anxiety brought on the old symptoms, and when he entered the hospital, on January 19th, he was exceedingly weak and pale; had headaches, bleeding at the nose and dizziness when standing. These symptoms have continued with occasional intermission up to the present date. On several occasions the bleedings were severe, lasting once for nearly twelve hours; the blood coming drop by drop from the right nostril. The temperature was usually normal,

but at times went up to 101° or 102°. For the past three weeks there has been no hæmorrhage, and his general health has improved, the headaches have disappeared and he takes nourishment better. His present condition is as follows:—You notice, in the first place, the extreme bloodlessness of the exposed regions, particularly marked in the face; but I would call your attention to a peculiarity in the colour of the skin, which is well marked in this case, and has been so in all of the cases which I have seen in this city. It is not blanched from simple bloodlessness as in the pallor of fear or hæmorrhage; but there is a peculiar sallow, dirty yellow or lemon tint, not the hue of jaundice, and, moreover, the conjunctivæ are not stained. It is also quite distinct from the greenish yellow tinge of the skin in chlorosis. The patient still has a fair amount of subcutaneous fat, though he has lost a good deal of flesh in the past three years. He is weak, easily tired, and it has been as much as he could do to get from the ward to the lecture room. His breath is short on exertion, and he feels faint and dizzy, when he stands for any time. The appetite is poor and the digestion weak, but he has never had vomiting. The bowels are regular, no diarrhœa. Pulse is 84 per minute, soft and weak. On listening to heart sounds, which are very distinct, there is a blowing systolic murmur at the base, evidently hæmic in character, and the venous hum is loud in the neck. There is no evidence of any pulmonary trouble. The examination of abdomen is negative; liver dulness, normal. Spleen dulness, about four inches in vertical diameter, edge cannot be felt under the ribs. Urine clear, reaction, acid, sp. gr. 1015. There are no cerebral symptoms; he has suffered from headaches, but not latterly. On examination of the eyes, retinal hæmorrhages are seen, and also pigmented spots, the result of old extravasations.

The examination of the blood yields the following results: With Gower's Hæmacytometer, red corpuscles per cubic millimetre, 970,000, 19.4 per hæmic unit, instead of about 5,000,000 in the c. m. The hæmoglobin, as estimated by Gower's Hæmachromometer, is only 20% of the normal, and about the same

percentage is obtained by Quincke's apparatus. The blood drop, when expressed, has not the full rich colour and consistency of normal blood, but is paler, thinner and watery. Under the microscope, the corpuscles show a great inequality in size, some are larger than normal, others very much smaller. Many are very irregular in outline. The colour of individual corpuscles is pretty good, a few nucleated red corpuscles exist. The white corpuscles are not materially increased, the proportion, when counted, 1 to 230 red. There is an entire absence of Schultze's granule masses, so common in the blood of debilitated individuals. I have put, for purposes of comparison, the blood of an anæmic girl under another microscope and you will be able to perceive a marked difference.

Summing up the chief symptoms, we have,—

1. Profound anæmia without any obvious cause.
2. Cardiac and vascular murmurs.
3. Repeated attacks of epistaxis, which began originally after the anæmia was established.
4. Retinal hæmorrhage.
5. Peculiar alterations in the histological character of the blood.

The clinical picture which Addison has left of the disease is unequalled, as you may gather from the following extract:—"It makes its approach in so slow and insidious a manner, that the patient can hardly fix a date to his earliest feeling of that languor which is soon to become so extreme. The countenance gets pale, the whites of the eyes become pearly, the general frame flabby rather than wasted; the pulse, perhaps, large but remarkably soft and compressible . . . ; there is an increasing indisposition to exertion with an uncomfortable feeling of faintness, or breathlessness on attempting it; the heart is readily made to palpitate; the whole surface of the body presents a blanched, smooth, and waxy appearance; the lips, gums and tongue, seem bloodless; the flabbiness of the solids increases; the appetite fails; extreme languor and faintness supervene, breathlessness and palpitations being produced by the most trifling exertion or emotion; some slight œdema is probably perceived about the ankles; the debility becomes extreme."\*

\* Addison's Works, New Sydenham Society, p. 212.



He says that these were "cases in which there had been no previous loss of blood, no exhausting diarrhoea, no chlorosis, no purpura, no renal, splenic, miasmatic, glandular, strumous, or malignant disease."

Of the individual symptoms of the affection, I shall not speak fully, as most of them are common to all forms of anæmia, but one or two demand special attention. I have already told you of the state of the blood in this patient, and of the remarkable diminution in the red corpuscles. Instead of 5,000,000 to the cubic millimetre, the number is reduced to 970,000. In over fifty cases of diseases, accompanied with wasting, in which I have carefully counted the corpuscles, pernicious anæmia is the only one in which I have met with a reduction in the red corpuscles below 1,000,000 to the cubic millimetre. Even in an instance of severe hæmorrhage—hæmoptysis extending over a week—and during which time the man lost nearly ten pounds (by measurement) of blood, the number of corpuscles was 1,390,000 per cubic millimetre. The reduction may be much more marked than in this case; the most striking instances which I have found recorded are given by Quincke,\* in one, 330,000 per c. m.; and in another, 143,000 per c. m.! Strange to say, this patient recovered after transfusion, and the number of corpuscles rose from 143,000 on the 22nd of May, to 1,234,000 per c. m. on the 5th of August.

The colour of the blood is much altered; the drop, as expressed from the finger tip, has not the rich red tint of health, but is lake coloured or like claret and water. In some forms of anæmia, particularly chlorosis, the hæmoglobin is greatly reduced, even when the number of red corpuscles maintains a fair standard. Thus, in two cases of chlorosis, while the globular richness was 87·8 and 92 per hæmic unit,† respectively, the hæmoglobin, as estimated by the hæma-chromometers of Quincke and Gower

was 64, and 66 per cent.; that is to say, the individual corpuscles were poor in colouring ingredients. In pernicious anæmia, the loss in colour is usually proportional to the corpuscular poverty as in this case, in which the red corpuscles are only 19·4 per hæmic unit, and the hæmoglobin 20%.

The microscopical characters of the blood in this disease are worthy of your closest attention, as I know of no disease in which that remarkably constant histological element, the red blood corpuscle, undergoes such important modifications. I have studied carefully the blood in six instances of the disease, and in all there has been a striking uniformity in the microscopic features, which are as follows:—

1. Remarkable variations in the size of the red corpuscles, three sorts being distinguishable; (a) Giant forms; usually not very abundant. I have measured some of these as much as  $\frac{1}{1700}$  and  $\frac{1}{1800}$  of an inch in diameter. (b) Medium-sized cells, such as ordinarily met with; they constitute the larger proportion. (c) Very small corpuscles—microcytes—tolerably numerous; they are globular, and of a deep colour; they range in diameter from  $\frac{1}{7000}$  to  $\frac{1}{8000}$  of an inch.

Quincke has coined a term to express this great discrepancy in size, Poikilocytosis.\* It is certainly a remarkable feature in the blood of this disease, and though not absolutely peculiar to it, yet, is much more marked, in my experience, than in leukæmia, splenic anæmia and Hodgkin's disease.

2. Great irregularity in the form of the corpuscle. The disc shape of the red blood cell is rarely departed from in health or disease, but in this affection, the margin of the corpuscles are indented and irregular, or there are various extensions of the stroma, giving to the corpuscles a balloon or hammer shape—alterations which cannot be mistaken for crenation.

3. The colourless corpuscles do not present any special characters, and are not actually, though they may be relatively, increased. The amœboid movements are active. In one or two instances they were reduced in size, and in a few cases in number.

\* *ποικίλος*, variously formed.

\* *Archiv. f. Klin. Medicin.* Bd. xx., 1877.

† "With normal blood the average number of corpuscles in two squares of the Hæmacytometer (containing '00002 cubic millimetres of blood is 100). I propose, therefore, to take this volume of blood, '00002 c. m., as the standard volume, and to term it "hæmic unit." Thus the number of red corpuscles per hæmic unit is the percentage proportion to health." (Gowers.)

4. Schultze's granules, so common in cachectic conditions, are absent.

5. In one case, nucleated red-blood corpuscles, such as occur normally in red marrow, were found.

In a large number of cases, hæmorrhages constitute an important symptom. Epistaxis is common, and this patient, as you heard, has had severe attacks. Retinal hæmorrhages frequently occur, and have been thought to be peculiar to the disease; but Litten\* has shown that they develop in the anæmia of cancer, and after severe loss of blood. In several of the cases which have occurred in this city, there were small cutaneous extravasations.

The *etiology* of the disease is, in many cases, obscure; but in others, well recognized predisposing causes may be traced. Of the recorded cases, the large proportion appear to have been in women, particularly in Switzerland, where the disease appears to prevail extensively, owing, doubtless, to local conditions. Thus, of ninety-three cases reported from the clinics of Berne and Zurich,† sixty-seven were females and twenty-six males. In England, the majority of cases have been males. Of eleven cases which I know of as occurring in this city, eight were males.

Among the more important causes which have been assigned, are: 1. Pregnancy and Parturition. Many of the cases on record have developed during pregnancy or shortly after delivery. It may be doubted whether such cases can be classed under the heading Idiopathic or Essential. 2. Defective food. A considerable proportion of the Berne and Zurich cases resulted from this cause, and were more correctly examples of inanition anæmia.

It is quite striking, in reading over the records of continental cases, to note how frequently this circumstance is mentioned, and the majority of the patients appear to have been derived from the lower classes; while here, and in England, many of the cases have been among the well-to-do. 3. Gastro-intestinal troubles, atonic dyspepsia or diarrhœa,

have preceded the onset of the anæmia in a large group of cases. 4. Grief, mental shock or worry, have been mentioned by writers as probable causes. In one of the cases which occurred here (Dr. Gardner) the failure in health began after the death of two sons.

In the present case none of these causes can be assigned.

The *diagnosis* is arrived at only by the exclusion of all possible affections which might cause, or be accompanied by, great poverty of blood. You must carefully inquire into the history and mode of onset, interrogate the various systems and organs in a searching and methodical manner, when, if no definite disease can be detected, the diagnosis of idiopathic or pernicious anæmia will probably be correct. The affections with which it would be most liable to be confounded, are: 1. Cancer of the stomach, some instances of which run a very latent course. In the case you have here, the gastric symptoms have not been marked, there is no tumour, nor tenderness, nor marked emaciation, and the disease has lasted a much longer time than cancer would. 2. The appearance of the patient and the retinal hæmorrhages suggest Bright's disease—and would still more if the ankles were swollen, as formerly—but examination of the urine is negative. No casts, no albumen. 3. From certain other blood diseases the diagnosis might be difficult, but scarcely in this instance. In leukæmia there might be the same pallor, the poverty of red blood corpuscles, the vascular murmurs, and the irregular, slight pyrexia, but we would have in addition, splenic enlargement, and a great increase in the colourless elements. Hodgkin's disease and splenic anæmia, while presenting a blood condition, closely resembling that of pernicious anæmia, would be distinguishable by the glandular enlargements. It is not improbable, however, that there is a relationship between these affections, which resemble each other so closely in certain clinical features. Litten\* gives a remarkable instance of anæmia following parturition, in which three days before death leukæmia of a high grade developed.

In the *morbid anatomy* of this affection there

\* *Berliner Klin. Wochenschrift*, 1877.

† Müller *Die pro. per. Anämie*, Zurich, 1877; Quincke, *Volkmann's Sammlung*, no. 100; and *Ziemssens Archiv*. Bds. xx. and xxv.

\* *Loc. cit.*



are three points of interest, the extreme bloodlessness of the organs and the small quantity of blood in the heart and vessels, the advanced fatty degeneration of the heart and other organs, and the condition of the bone marrow.

[In certain cases, having a close resemblance to pernicious anæmia, Dr. Fenwick, of the London Hospital, has described an atrophy of the gland structures of the stomach; but what connection that has with the anæmia—whether as cause or effect—appears doubtful. In future, the stomach should be carefully examined in these cases.]

The bloodlessness of the organs is extreme, and the heart and arteries almost empty; in one instance I could collect only 3ij of blood from the chambers of the heart and the aorta. The fatty degeneration is secondary to the anæmia, and is a very constant change. Formerly, cases of this disease were described by some writers as, "idiopathic fatty degeneration." The alteration in the bone marrow has attracted considerable attention, and is believed by certain pathologists to have an important connection with the disease. The long bones have been found to contain a rich red marrow, which has replaced the normal fatty tissue of the medullary canals of bones of adults. This consists of granular marrow cells, small lymphoid corpuscles, myeloplques, red blood corpuscles, and large nucleated red corpuscles. The latter have been spoken of by many writers as if they were not a usual constituent of adult marrow; according to my observations they can always be found in the *red marrow* of the ribs and short bones, often in considerable number. [I am surprised that so good an observer as Prof. Rutherford, of Edinburgh, should state, in the little work on Practical Histology, which many of you use, that he has never been able to see these bodies in the marrow.]

This change in the medulla of the bones, in pernicious anæmia, was first studied by Pepper, Cohnheim and myself, and we were inclined to attribute to it a somewhat important rôle in the pathology of the disease. The position which I took in the matter may be gathered from the following remarks in a paper before the Canada Medical Association in 1877:

"Clinically, these cases present certain similarities to those of leukæmia and Hodgkin's disease, or pseudo-leukæmia. Now these latter diseases differ chiefly in this, viz., that in leukæmia the colourless blood corpuscles are in excess; in pseudo-leukæmia they are not. Both present three varieties: 1st, the splenic, in which the chief lesion is the great enlargement of the spleen; 2nd, the lymphatic, in which the lymph glands throughout the body are mainly affected; and 3rd, the researches of Neumann, Mosler, and others have made us acquainted with a variety known as the myelogenous or medullary, in which the marrow of the bones is the seat of disease. This tissue is now generally regarded as sharing, in the young animal at any rate, with the spleen and lymph glands, in the formation of blood corpuscles. In the long bones of the adult it is in a state of atrophy, and its place, in great part, supplied by fat. In many cases of leukæmia and pseudo-leukæmia, it increases, becomes more vascular, its cellular elements multiply, nucleated red blood corpuscles, such as occur in the embryo, are formed, and the whole tissue passes into a condition of hyperplasia, strictly analogous to that affecting the spleen and lymphatic glands. This may be, as in a case recently reported by Mosler, the primary lesion in leukæmia, and the development of the marrow may produce definite symptoms, such as swelling and tenderness of certain parts of the bones; so that the myelogenous forms of these affections are now well recognized. Clinically, the myelogenous form of pseudo-leukæmia, though rarely uncomplicated, presents such a similarity to pernicious anæmia that Jaccoud and Immerman suggested the identity of the two affections, while Prof. Pepper, declared distinctly that pernicious anæmia was 'merely the simple medullary form of pseudo-leukæmia.'

"In the present state of our knowledge it may, I think, be reasonably affirmed that certain cases of idiopathic anæmia may be placed in the category of myelogenous affections. To many it may appear far-fetched to seek, in the altered condition of the bone marrow, an explanation of the extreme anæmia of this disease, but the reports of numerous cases

leave no room for doubt that a serious alteration in its structure, and a return in adult life to its embryonic state, may profoundly influence the composition of the blood, producing anæmia and death. It must be borne in mind that the red marrow in the short bones of an adult probably equals in bulk the constituents of the spleen, and structurally is very similar to that organ and to the lymphatic glands. In the long bones it is largely replaced by fat, but traces of it still remain. Now, granting that the marrow is a tissue which shares in the blood-making functions, it is quite as reasonable to suppose that, if hyperplasia of the elements of the spleen can lead to serious disturbance in the composition of the blood, producing the splenic form of leukæmia or pseudo-leukæmia, according as the colourless corpuscles of the blood are increased or not, so a general increase of the constituents of the marrow may induce similar conditions. For it is to be remembered that, in a general hyperplasia of the marrow, the actual amount of lymphoid tissue in the osseous system equals or perhaps exceeds, that of an enlarged spleen. Why a simple hyperplasia of this tissue should interfere with the elaboration of the blood, altering in the one case the mutual proportion of the corpuscles, and in the other simply reducing the total number; we do not know, but we are just as ignorant why an enlarged spleen and lymphatic glands should produce in the one case leukæmia, and in the other not."

When the paper was published, from which I have read you these extracts, a systematic investigation into the condition of the bone marrow, in various diseases, had not been made; but since then a number of observers have found this hyperplasia of the medulla in many chronic diseases, particularly in phthisis and cancer. In a considerable number of examinations, I have also met instances of red marrow in the long bones in chronic wasting disease, but not so frequently as Litten and Orth,\* or Blechmann.† In only two instances have I found such intense and universal hyperplasia of this tissue as in the three instances of pernicious anæmia, which I have had an opportunity of examining. On the other hand, in

eight cases of phthisis, and in two of cancer, (œsophageal and pyloric) I have found the marrow of the long bones fatty. I think that we have still a good deal to learn with reference to the bone marrow. I am not quite disposed to give up the view that some instances of pernicious anæmia may be of myelogenous origin. The similarity of the clinical features to leukæmia and pseudo-leukæmia, and the transition in Litten's case, from pernicious anæmia to leukæmia, suggest a close relationship.

Such a profound anæmia, as in the case before you, might result from one of two causes: 1st. A faulty formation of blood corpuscles—anhæmatosis, or loss of blood, either by hæmorrhage, chronic discharges or excessive destruction of the coloured cells—hæmophthisis.

Very many of the reported cases of this disease do not come strictly under the definition as given by Addison; but there have been various causes at work, productive of hæmophthisis. Dr. Howard holds that "all the various forms of anæmia, *i.e.*, forms, determined by the conditions, under which they occur, may occasionally take on progressive and pernicious characters." And this is the view taken by Quincke.

Dr. Howard further maintains that there is not a distinct variety of anæmia having an etiology and pathology peculiar to itself, and it is upon this point, particularly, that more light is wanted. The cases require sifting; and, for my own part, I would insist, with Immerman, "that no case should be accepted as belonging to this disease, unless, besides being an instance of extreme and fatal anæmia, it is also impossible to account, either rationally or empirically, for the progressive course of the anæmic symptoms."\*

The *prognosis* is most unfavourable; all of our Montreal cases have died. Of the sixty-four Zurich cases, given in Müller's monograph, only seven recovered. Of Quincke's thirty-one cases, eleven are stated to have recovered; but you must remember, with reference to many of these Switzerland cases, that they come more properly under the head of inanition anæmia.

\* Quoted by Hartshorne in his article on "Prog. Pernicious Anæmia," in the American edition of Reynolds's System, Vol. III.

‡ *Berliner Klin. Wochenschrift*, 1878.

† *Archiv. der. Heilkunde*, 1878.



The duration of the disease is from three months to a year. This case is remarkable as lasting for over three years. One of Biermer's patients lived for five years after the first onset of the symptoms. The most rapid course in his cases was seven weeks.

The *treatment* is not very satisfactory. Special attention must be given to the weak digestion which almost invariably accompanies the disease. Iron, in some form, should be employed; this patient has been taking Bland's pills for some weeks, but without any apparent benefit. Argenic should be given, as several successful cases have been reported under its use; it may be given in combination with the iron. Our patient has not been taking it long enough for us to say whether it is doing any good. Transfusion of blood has been employed in many cases, but without very encouraging results. Quincke, however, has had several successful cases. He transfuses into the radial artery. The transfusion of milk, as first employed by my old preceptors, the late Drs. Hodder and Bovell, of Toronto, is stated to have cured, even after blood transfusion had failed.

### TEACHING OF OBSTETRICS IN VIENNA.

BY J. F. W. ROSS, M.B., L.R.C.P., LOND.

Vienna has many great surgeons, great physicians and great obstetricians and gynaecologists. It is a great centre from which emanate more new theories and more new features of practice than any other place. No such advantages are to be enjoyed by the student of medicine with its various branches out of the "Kaiserstadt" as within it. With fair faculties, diligence in his studies and that ruling god with the Viennese, money, he can here, in a few years, perfect any speciality he may wish to follow.

We will take, as an example, the clinic of Professor Carl Braun von Fernwald, who is said to have the largest obstetric and gynaecological practice of the present day. He has his own wards set apart in the hospital—the Allgemeine Krankenhaus; residing in this section, are his two assistants, both thoroughly versed in this branch of our profession. Under their

guidance are the nurses—six of them midwives—and the students entered for the practice of the clinic. The nine to ten thousand annual deliveries are divided between the three clinics. From 8 a.m. to 8 p.m. on Monday, cases are received say in clinic No. 1. From 8 p.m. Monday to 8 a.m. Tuesday, in clinic No. 2. From 8 a.m. Tuesday to 8 p.m. of the same day, in clinic No. 3. Then from 8 p.m. of Tuesday to 8 a.m. on Wednesday, clinic No. 1 begins again to receive cases. This leaves twelve hours for purposes of disinfecting, ventilating and scrubbing, in every thirty-six. The protracted cases are put in a small room with four beds adjoining the large ward.

The patients on those days when the reception is from 8 a.m. to 8 p.m., assemble at 4 o'clock in the ward, and after having their temperature taken are in turn examined externally by the students present, to enable them to form their diagnosis from palpation and auscultation alone. Then the assistant comes and questions whomever happens to be examining at the time, "When had she her last period?" "How long has she been pregnant?" "When should labour set in?" "Is there much amniotic fluid?" "What is the position?" "Where is the head, where the breech, and where the back?" "Is the child living?" "Where is the foetal heart heard most plainly?" "Is there but one fetus?" "Is she a primipara or multipara, if multipara, is there any history of instrumental interference, of unavoidable, accidental, post-partum hæmorrhage, or has she ever miscarried?" "Is there anything in the bones of the arms or legs to lead you to suspect a deformed pelvis?" "What are the external measurements?" After going over some, if not all of these points he examines per vaginam. Should labour have begun or the temperature be above 30° C., only one student is allowed to examine her, and he must take the case to its termination. If below thirty, three or four examine her after the assistant. Taking a case simply means writing one's name on the board over the head of the patient's bed if none is already there. Since the puerperal epidemic, in November, 1879, new rules are being enforced. In November, after thirty fatal cases, the wards

were closed for two weeks. Before examining p.v., the hands must be thoroughly disinfected in 5% carbolic acid, and soap rinsed, and then dipped in sol. of permanganate of potash. If the student takes a case he must not take another until it is over. The effect of this rule has been to perfect his powers of diagnosis by external palpation. If he finds anything interesting, such as a face or breech presentation or twins, he at once takes the case. Should he find any deformity, or enlargement of the ends of the long bones, he would take it, hoping to find a contracted pelvis. If afraid of it being a normal case, he asks a nurse to examine internally for him; this they will generally do if he has shown them a little courtesy. New comers generally begin by supporting the perineum of primiparæ, and extracting the placenta.

In breech cases the assistant is present to assist, if necessary, or to take charge if he thinks the student incompetent. They are very particular about the exact position of the child to prevent the mistake of introducing the wrong hand when extracting the head. A napkin is rolled round the arm corresponding to the side on which is the child's mouth, the body of the child laid along it, the fingers put in the mouth one on each side of the lower jaw, the other hand applied to the nape of the neck, traction made downwards and forwards, and the child's body is carried up over the abdomen of the mother while the assistant presses firmly on the fundus uteri to supply its place if inert and of a tired vagina, thus bringing the danger of asphyxia to a minimum. Braun is against the use of forceps on the head in a breech case. He says that if they cannot be delivered by the above method, instrumental interference would be too late, in most cases, to save the child, and if delay be due to an undilated os, or an abnormal rotation and locking of the chin on the pubis, it would be productive of danger to the mother. If a breech present in a primipara or a contracted pelvis, they bring down the foot, or both feet, if possible. Diagnosing the sex in breech cases they teach that if you feel nothing it is a male, if two tumefactions feeling like two testicles, it is a female, because the labia became hard and swollen.

The forceps are not used so frequently as in

Dublin. They wait for two hours after the os is fully dilated and the head arrested in its descent. By adhering to this rule much unnecessary suffering is caused. Two cranial positions only are recognized, the first is our first and third, the second is our second and fourth. Simpson's medium-sized forceps are the ones used. Forceps are rarely applied at the brim. Braun never applies them. In preference he turns or performs craniotomy. Should turning result unsuccessfully, craniotomy can be performed without scruple on a dead child—averting the horror of killing a strong fœtus. If the heart-sounds are irregular, or if meconium is discharged, the os being dilated, forceps are applied at once. To apply them, the patient is bolstered on rubber covered pillows across the bed. She lies on her back. The blades are introduced in the usual way, a towel placed between the handles to prevent undue compression of the head. Traction is made and then the head is pushed back again, the instruments re-applied, and again traction is made. After each traction an examination is made to watch the rotation. The operation which puzzles most students is that for rectifying an abnormal rotation with the forceps. The rule they observe is to introduce the blades, so that the handles will point to the thigh nearest the occiput. One thing is carefully attended to, and that is to rotate so that the rectum and bladder incur no danger of being lacerated by the points of the instruments. The centre of the blades should be the pivot on which rotation is made and not the points.

Before turning, the exact position of the child is ascertained. That hand is introduced which corresponds to the side opposite to the head. It is passed over the abdomen to the feet. If possible, and the pelvis is not contracted, the shoulder is shoved up, the head brought to the brim, kept there by a pillow, and the woman kept on the side opposite to that on which the head was. Turning is performed in those cases in which rapid delivery is necessary, as placenta prævia, eclampsia, rupture of the uterus; also in cases of moderate pelvic contraction and transverse presentations, and some cases of prolapsus funis. After the feet have been brought down traction is



only made during the pains to prevent the arms slipping up over the head, abnormal rotation or constriction of the neck of the foetus by an insufficiently dilated os. The fillet is always used. Turning is always performed with the patient in the dorsal position.

The perineum is supported in primiparæ, and for this purpose they are turned on the left side. The labia are gradually stripped back from the head, and often its progress is retarded by pressure during a pain to avoid rupture. If very tense and of a bluish colour, episiotomy is performed; *i.e.*, an incision is made on either side to direct a tear from the rectum and relieve the tension. If a rupture occurs, "serrefines" are applied, and the legs bound together thus avoiding much of the unpleasantness incident upon stitching.

The placenta is removed by Crede's method, and in normal cases, pressure on the fundus is kept up for about five minutes. If there is any tendency to flood from inertia the uterus is kept contracted by pressing and rubbing it with the hand until it can be brought under the influence of ergot. Full doses of ergot are given in all cases. A tin, holding about a quart of lukewarm 2% solution of acid carbol, is hung on the wall at the head of the bed. From the bottom of the tin runs a tube, fitted at the end with a gutta-percha shoulder, into which a nozzle fits. The nozzle is bent at about an angle of 120° to better adapt itself to the upward and forward course of the vagina. The nozzle is filled with the fluid, introduced into the vagina, and then fitted into the shoulder of the tube. The stop-cock is turned and a steady stream flows without much force into the canal. This gives a great sense of comfort to the patient.

The new-born babes are laid out on a table until the nurses are at liberty. Sometimes six or eight may be there at once, waiting to be washed, dressed, and returned to their mothers; or, perhaps, it may occasionally happen to some other baby's mother. With so few distinguishing marks, mistakes might occur in the hurry, when one thinks that as many as thirty-six were born in this one ward, with its twenty beds, between the hours of 8 a.m. and 8 p.m. One Friday morning, fifteen went down to be christened.

About an hour after delivery the mother and child are taken away on a litter to the convalescent wards, where, if all goes on well, they remain for nine days. If in good health, they are then transferred to the infants' home, where they nurse their own child and that of some mother whose case has not terminated so favourably. For two weeks they are bound to stay here, and if willing, can remain longer. For this they receive their board and a small wage beside. Then, returning home, they take or leave their offspring as they choose. If it be left, as is done by many, for 50% of these children are illegitimate, there are certain times at which they can reclaim it. This privilege is granted until the child is fifteen years old, when all trace of it is lost to the parents. The system, it is said, was instituted to benefit (?) the soldiery, discouraging marriage among them, and still allowing them to gratify their desires without inconvenience.

## TWO CASES OF DROPSY FROM ANÆMIA FOLLOWING ACUTE PNEUMONIA IN THE AGED—RECOVERY.

BY R. WHITEMAN, M.B., SHAKESPEARE, ONT.

The following cases I consider worth reporting, not from anything special either in the cases themselves, or in the line of treatment adopted, but as showing the necessity of securing complete convalescence before treatment is abandoned; as it is frequently the case that a patient beginning to feel relief from the severest symptoms of an acute disease, and growing weary of restraint, though still weak and anæmic, will refuse any longer to submit to treatment.

Of course, in such cases it is the duty of the physician to point out the dangers of an incomplete cure, yet for various motives he may not feel disposed to press the matter too strongly lest on the one hand he should be suspected of a desire to prolong his bill, or the patient, being under favourable hygienic conditions, may continue to improve, though slowly, and thus in future discredit him with the family.

These cases of incomplete convalescence occur most frequently in families who have been so fortunate as never to require much medical

assistance, or amongst those who have been badly humbugged by quacks, until they are disposed to look with suspicion upon all medical men. We seldom find such cases in families who have learned to place confidence in the ability and honesty of their family physician; or if we do, the fault is his, not theirs; as where properly looked after they ought very rarely to occur.

Of course, aged people are more likely to suffer in this way than the young, as in them there is less of the (*vis medicatrix nature*) vital force which forms so important an element in every recovery.

*Case I.*—Mr. L—, aged 65, German. Visited March 25th, 1880; found him suffering from severe pneumonia of posterior portion of lower and middle and whole of upper lobe of right lung. The case, though severe, ran a favourable course under ordinary treatment, viz: mild counter irritation with saline cathartics, opium, ammonia, good nourishment, &c., internally. I saw him frequently up to April 10th, when he began to breathe easily and gain some strength, having a good appetite. He then thought he would not take any more medicine. I pointed out that he was not yet well but told him if he wished he might quit for awhile, and if he continued to improve, all right, if not, send me word. I heard nothing more from him for about ten days when I was sent for again, and informed that his disease had turned into dropsy, and, of course, nothing more could be done for him except to relieve his sufferings, as his legs and abdomen were considerably swollen. After satisfying myself that there was no organic disease of his heart, and no albumen in his urine, I gave a somewhat favourable prognosis and began with blue pill, followed by saline cathartic, also a mixture containing Tr. Ferri Mur., Tr. Nuc. Vom., and Spts. Aeth. Nit., in pretty full doses, to be repeated every four hours. Had him kept in bed, and bandaged his legs, instructing the family to remove the bandages, wash the legs, and re-apply them whenever they got loose. In four or five days the dropsy had all disappeared, and continuing his iron mixture it did not return.

*Case II.*—Mr. W—, aged 78, German. I

was first called here Dec. 13th, 1880, and found him suffering from acute pneumonia, chiefly confined to posterior portions of right lung. His cough was very troublesome, for which I prescribed an opiate to be given as required to relieve cough and procure some sleep. The treatment was much as in the previous case. On my second visit I was informed that the only medicine he would take was that for the relief of his cough, as he found that it gave relief, and he did not expect to get well any way. Finding that his resolution was fixed, I told the family that there was no use of my visiting him if he did not follow my directions; and that unless he changed his mind, and notified me to that effect, I would not come back. He continued very poorly, sending occasionally for cough mixture; but I saw no more of him until March 22, 1881, when his son came to tell me that he was very bad with dropsy—feet, legs, and abdomen very much swollen.

After a careful examination of his heart, and finding his urine free from albumen, I gave a favourable prognosis. As he was in great distress I concluded to tap at once, and by means of a large aspirator needle I took from him one gallon and about a teacup full of fluid, which gave great relief. The rest of the treatment was similar to that of the previous case. I saw him again on March 24th, when the swelling was very much reduced. He now took his medicine very willingly, and when I inquired if he would take it if I made it more bitter, wishing to add *nux vomica* to the iron, he replied that he would take anything I gave him. In fact, I found that his faith in the profession had very much increased, as he obeyed orders willingly.

He continued steadily to improve, taking the iron and compound jalap powder when constive without any return of the swelling, until my last call, as I was passing his residence, April 11th, when I was surprised to find him so hearty, entirely free from dropsy, with good appetite, being up all day, and rapidly gaining strength.

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Alexis St. Martin, the bearer of the Gastric Fistula, is dead.



## CASES IN PRACTICE.

BY J. E. GRAHAM, M.D., L.R.C.P., LOND.

Lecturer on Dermatology in the Toronto School of Medicine.

## PECULIAR PUSTULAR ERUPTION FROM EXPOSURE TO RAYS OF SUN.

Peculiar pustular eruption on the skin produced by the action of the sun's rays. Came to me July, '80, when the following notes were taken :

A. B., aged six., born in Canada. For the last  $4\frac{1}{2}$  years has lived in a town in Western Ontario. Family history, good ; no trace of hereditary disease in any of her relatives.

Present illness : About two years ago last April some pimples appeared on the face and hands. About a week after their appearance she took diphtheria and during her confinement in the house from this disease, the spots faded away without leaving any scars. Similar spots appeared in June after she commenced to go out of doors. This time they grew larger, filled with matter, attaining their full size in two or three days, when a dark spot appeared in the centre of each, and gradually a scab formed, which in a short time fell off. During the summer of '78 several successive crops of these spots appeared which passed through the successive stages as above described, in about nine or ten days and then went away leaving slight cicatrices. They only appeared after the patient was exposed to the sun, and the severity of the attacks seemed to be in proportion to the amount of the previous exposure.

In the fall of '78 the eruption disappeared altogether and remained away until the latter part of the winter of '78-'79. It then reappeared after the exposure on a bright sunny day when snow was on the ground. That portion of the face which was protected by the winter hood was not affected. While wearing gloves, the hands were not affected, but they became so when she ceased to wear the gloves. The wrists which were covered for a time in the spring were not affected. In the summer, however, they also became affected. The eruption was not accompanied by much itching. A slight irritation was noticed on its first appearance.

Patient had scarlatina in the summer of

1879. This disease had no effect on the eruption, except that it faded away on account of the confinement to the house. Patient has constantly worn a glove since the 1st of May last on her left hand. This hand has not been at all affected.

As a general rule the eruption has been much less during the winter season, owing to her being kept in the house. Her mother thinks that the rays of the sun in the winter have not quite the same effect as in summer. The eruption always appears after she has been out for a few hours when the sun is shining. It will also appear sometimes after she has been sitting at an open window with the warm breeze blowing on her. On a cloudy day when the sun is completely concealed, no effect is produced.

She had a slight attack of ague in the spring and some symptoms of that disease presented themselves during the summer. Her appetite is fairly good. She is fond of acids, vinegar, &c.

*Present Condition, July 1880.*—There is a copious eruption on the face, ears and right hand. On the face it is made up for the most part of ordinary sized pustules, some being umbilicated and resembling those of small-pox, others were covered by scabs, others presented cicatrices, the scabs having fallen off. The nose is swollen ; the lips are much swollen and covered with scabs. The ears also are covered with large pustules. Some of the pustules on the face were as large as a ten cent piece, some much larger. Patient was vaccinated when she was eight months old. Nothing unusual followed the vaccination.

Nearly all applications seemed to aggravate the disease, and all forms of internal treatment adopted were of no avail.

*Remarks.*—The patient was first seen by me in January '80, when notes of her case were taken. I saw her again in July, but having to leave town, I left her in charge of Dr. A. H. Wright, who saw her when one of the attacks of eruption was at its height and who wrote the history of the case as given above. The eruption appears to be solely the effect of exposure to the sun's rays, and is of a very severe character indeed. So far as I have been able

to study the literature of the subject I have not found a similar case. At first sight without going into the history of the case, one might take the case for one of small-pox, the pustular eruption was so similar. As a rule, the pustules remained discrete throughout the attack; in some places, however, they were confluent. The inflammation extended to the derma as evidenced by the scars which remained. These scars, however, were in many instances the result of scratching rather than of the disease itself. In places which had not been irritated the cicatrization was very slight.

#### SPASMODIC SPINAL PARALYSIS.

A. P., aged forty-two, born in Canada, resides in a small town in a northern part of Ontario. His family history is good. Some of his relatives both on his father and mother's side suffered from rheumatism. Patient was engaged in the lumbering business, leading a very active life until about eight years ago; since that time he has kept a hotel. About two years before he left the lumbering business, he was exposed to cold, working in the water. He was then seized with a violent pain in the left hip joint which appears to have been of a rheumatic character. It prevented him from working for some time. The present disease commenced two years and a half ago. He noticed first pain in the left hip, and afterwards numbness in the leg. In a short time he found that he had not the proper use of the limb, and contractures began to take place. In about six months after the commencement of the disease the right leg also became affected, but was not so bad as the left until a little over a year ago. Since that time the right has been worse than the left. Last summer there was some improvement in both legs, so much so that he could go around with the aid of crutches.

*Present Condition.*—Patient is a tall, well-developed man and from his appearance one would consider him to be in excellent health. There is no wasting of the limbs. He sits on a chair or lies on the bed; not being able to move about even on crutches.

There are present, numbness of the feet, paresis, more particularly of muscles connecting

the thighs with the trunk, diminution of sensibility, contractures of the limbs and tremors. The patellar tendon reflex is very much exaggerated. Patient is very sensitive to cold. He can pass water without great difficulty, but has lost control to some extent over the bowels.

The diminution of sensibility is quite easily made out by the aesthesiometer. The contractures are very marked and cause the patient more annoyance than any other symptom. They are sometimes brought on by attempts at movements, and sometimes when the foot touches the cold floor. He states that when he has an inclination to have the bowels move, he must get out of bed at once as he cannot control the sphincter. Very often at this critical moment he will be seized by the contractures, one leg going in one direction and the other in another. At such time he would lose entire control of the limbs. The contractures last for some seconds, after which he can gradually move the limbs to their proper position. He remained in the hospital for a few days and then returned home.

*Remarks.*—This would appear to be a case of spasmodic spinal paralysis with some symptoms of sclerosis of the posterior columns. The slight loss of sensibility and the partial loss of control over the sphincter are symptoms not met with in spasmodic spinal paralysis, at least not until later stages of the disease, as it is described by Erb in Ziemssen's *Encyclopædia*. It is probable that the sclerosis in this case affected not only the lateral columns but also to some extent the posterior root zones.

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A RARE OCCURRENCE.—On the 16th of April last as Dr. Cameron, of this city, was engaged in applying a Sayre's jacket to a young lady, about twenty years of age, affected with rotary lateral curvature of the spine, the following incident occurred:—The patient, a tall, well developed young lady, had suffered from scoliosis for the last six years. Three years ago Sayre applied a plaster jacket and recommended daily self suspension, which has been regularly practised since, the jacket being renewed once every six or eight weeks. During the suspen-



sion by collar and axilla straps—patient's toes just touching floor—it was observed that the fingers and palm of the left hand became and remained of a dead white hue, and about the conclusion of the process, not unusually prolonged, she complained of being faint. The face was observed to be extremely pale but in a couple of moments the angio-tetany gave way to paralysis and the vessels of the face became turgid and distended, consciousness was lost, slight muscular contractions occurred with opisthotonos, a gurgle in the throat or low cry was uttered and the tongue bitten. The patient was immediately let down and laid upon a contiguous bed and in two or three minutes consciousness returned, and nothing remained to mark the occurrence save a little nausea and faintness lasting about an hour. The jacket was unbroken and the patient returned home after relating that twice before she had fainted during the application of a jacket, and once before during self-suspension.

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### Selections: Medicine.

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#### THE CLINICAL FEATURES OF PLEURAL EFFUSIONS.

Dr. Broadbent read a paper upon "Some Points in the Clinical History of Effusion into the Pleural Cavity." He first enumerated and explained the relative importance of the physical signs of pleural effusion, and pointed out that the curved line of dulness was due to the manner in which the lung shrinks around its root, and as the fluid rises the vocal resonance and vibration become exaggerated over that part of the chest-wall where the lung is still in contact. When the cavity is full of fluid the respiratory murmur may be conducted for a short distance across the back from the unaffected lung. Sometimes, however, the lung was prevented from collapsing by adhesions, by consolidation, or congestion; and he believed the persistence of bronchial breathing in such cases was due to imperfect collapse of lung, although the fluid was in large amount. The chief point he wished to urge was that while the ordinary signs of effusion into the pleural cavity—dulness, extinction of vocal fremitus,

diminution of vocal resonance, the limitation of bronchial breathing to the region of the root of the lung—show that the lung retreats and shrinks before the fluid, loud tubular breath sounds at the base of the lung posteriorly and over the lateral and anterior aspect of the chest show that the lung has not entirely retreated, but that it retains a certain volume, and is more or less deeply immersed in the fluid. The patency of the bronchi and the partial condensation of the lung, favour the transmission of sonorous vibrations. It is in these circumstances that *œgophony* is heard most distinctly and widely—from the thin layer of fluid intercepting some vibrations and transmitting others—conditions which ordinarily exist only in the earlier stages of effusion. In some of these cases there may occur some degree of vocal vibration at a period when the amount of fluid is sufficient to give dulness on percussion over the entire lung. Paracentesis would be of comparatively little value in such conditions, for the quantity of fluid is small, and the consolidation of the lung would persist after its removal; and most cases of this sort get well without resort to paracentesis. In one such case only 30oz. of fluid could be withdrawn. The conditions are met with in the pleural effusion of renal disease, often accompanied by congestion, and partial consolidation of the lung preventing its collapse; also, in effusions which rapidly became purulent, as in *empyema* in children. Apart from these cases, the signs indicative of a large congested lung deeply immersed in the fluid are prognostic of rapid absorption, and Dr. Broadbent had seen this now in a sufficient number of instances to enable him to predict with considerable confidence the recovery of the patient without paracentesis and in a comparatively short time. One of the first steps towards recovery is a rather sudden disappearance of the tubular breathing and the substitution of the more ordinary signs of simple effusion; and it is probable that the congested lung has relieved itself by diffusion of serum into the pleural cavity, and that the amount of fluid there is actually increased. In conclusion, Dr. Broadbent stated the rules which guide him in recommending paracentesis. It should be resorted to at once when

there is serious continued or paroxysmal dyspnoea; but in the absence of urgent symptoms a week or ten days may be given after one side of the chest is full, on the chance that absorption may set in, and a longer period still when the lung has not greatly shrunk. Old age, phthisis, or a phthisical tendency, are reasons for early tapping, as also is the existence of disease of the kidneys. The spot for puncture is the eighth space, in a line with the angle of the scapula, and he had come to prefer the common trocar and cannula, with antiseptic precautions to the aspirator. The whole of the fluid should never be removed, or attempted to be. Where the effusion has lasted some time frequent partial emptyings are to be preferred.

Dr. C. T. Williams referred to a case of pleural effusion with presence of marked bronchial breathing and vocal vibration, and alluded to the valuable aid in diagnosis rendered by the use of a hypodermic syringe.

Dr. De Haviland Hall mentioned a case of sarcomatous growth filling the pleural sac and collapse of lung, yet with presence of vocal fremitus. In one case he had withdrawn 107 ounces of fluid, and he asked the author as to the amount he would recommend to be withdrawn.

Dr. Muir asked for information as to other modes of treatment.

Dr. Habershon spoke of the various forms of pleural effusion—e. g., in renal and in cardiac disease, secondary to pneumonia or due to primary pleuritis. He recalled a case of Dr. Addison's where a small area of bronchial breathing existed, surrounded by complete dulness and absent breath-sounds. The autopsy revealed a portion of lung adherent to the chest-wall at that spot. He pointed out that many cases recover if left alone. If there were high temperature, hectic fever, and tendency to tubercular disease, and if dyspnoea were present, he would advise paracentesis, especially if empyema were suspected.

Dr. Hare said the physical signs were often misleading, especially in children; the presence of vocal fremitus and respiratory murmur on the affected side was only to be accounted for by conduction from the healthy side, through the compressed lung and fluid.

Dr. Wharry asked how far vocal fremitus and tubular breathing were indications of the existence of uncollapsed lung in the fluid. He had seen at least one such case where these signs were absent. What were the author's reasons for assuming that exudation took place from the lung into the pleura in certain cases.

Dr. Gilbert Smith agreed with Dr. Hare as to the difficulty of diagnosis in children. He instanced a case where the lung was wholly collapsed, notwithstanding presence of fremitus and tubular breathing, and asked whether a purulent effusion did not conduct vibrations better than a serous one. He also asked whether the disappearance of these signs would not be better explained by an increase in the effusion and pressure on the lung than by an exudation from the lung itself.

Dr. Broadbent, in reply, said he had not seen cases of vocal vibration and bronchial breathing with collapsed lung, nor could he explain such. The persistence of vesicular breathing implied the existence of a non-collapsed lung. He did not consider that increase of pressure explained the disappearance of bronchial breathing, for almost invariably improvement quickly followed—ushered in by returning apical resonance. He had not practised injections into the chest in serous effusions, but had frequently and with benefit employed solutions of iodine in cases of empyema. He now preferred to use the simple trocar inserted near the angle of the scapula; this allowed of the withdrawal of the right amount of fluid, while the entrance of air did no harm. If the aspirator were used it was his practice to stop as soon as the patient became distressed or attacked with cough. Eighty-four ounces was the largest amount he had ever drawn off.—*London Lancet.*

CHLOROFORM AND CHLORAL HYDRATE IN COD LIVER OIL.—Dr. Hager states that the addition of 10 drops of chloroform in 100 grammes of cod liver oil renders it perfectly agreeable and palatable to take, without the slightest degree impairing its therapeutical value; or 10 grammes crystallised pure chloral hydrate, dissolved by digestion in a sand bath in 200 grammes of cod liver oil, renders the oil more palatable. The latter is recommended in consumption; it diminishes night sweats, produces sound sleep, and improves the appetite. The dose is from four to six tablespoonfuls daily.



### DELAYED PHYSICAL SIGNS IN PNEUMONIA.

Mr. Tyson (of Folkestone) read notes, at Clinical Society of London, of cases of Acute Pneumonia, in which the usual physical signs of the disease appeared late in the case.—Case 1. A man, aged sixty-four, caught cold, whilst driving on April 4th, 1880, and next day was compelled to give up work. He was seen for the first time on the 8th, when he complained of pain in the chest, and expectorated some tenacious mucus. There were no abnormal physical signs. Temperature 103; pulse 88; respiration 30; urine albuminous. On the 11th slight dulness appeared at the base of the left lung; fever was high. On the 12th (eight days after the chill) there was well-marked dulness, bronchial breathing, and bronchophony. He was very feeble, and died on the 15th.—Case 2. A female, aged twenty-five, in Guy's Hospital under the care of Dr. Pye-Smith, taken ill three days before admission, when the temperature was 104°. Signs of pneumonic consolidation appeared on the sixth day, and death took place on the seventh. There was grey hepatisation of the right upper lobe.—Case 3. A male, aged fifty, in whom no dulness was discovered till the sixth day. Death occurred on the tenth day. In two other cases Mr. Tyson had marked the absence of physical signs until the fifth day. He referred to the statement made by Dr. Bowles, that in asthmatic subjects attacked with pneumonia dulness often did not develop till four or five days after the seizure. After quoting passages from Ziemssen's *Cyclopædia* and Trousseau's lectures to show that such a late development of physical signs was not generally acknowledged, he concluded by stating that this retardation of signs occurred more frequently than was generally supposed, and might be attributed to the central part of the lung being primarily affected. In such cases the onset of the attack, the pyrexia, and the altered pulse-respiration ratio should be relied on as diagnostic points.—Dr. F. Taylor confirmed the author's statement as to the relative frequency with which the physical signs appeared late in the disease, and quoted a case which came to

the out-patient department with a history pointing to pneumonia. The physical signs were not apparent, although it was about the fourth day; but the patient coughed up some rusty sputa and was admitted. Soon afterwards physical signs became developed. In another case the delayed signs appeared before the rusty expectoration.—Dr. Andrew Clark said the paper was an important contribution to the literature of the subject, for anomalous and capricious cases of pneumonia were imperfectly recorded; but he did not think it added much to the knowledge of experienced men. He was constantly meeting with cases in which constitutional evidence of pneumonia long preceded the appearance of local signs. He would mention three such cases. One was a case of a gentleman he saw in consultation with Dr. Stephen. After a slight rigor the temperature rose to 101°, and for seven days there was no evidence of the disease, except the general distress, rapid breathing, and altered pulse-respiration ratio. The physical signs of pneumonia appeared on the eighth day. Another case was that of a gentleman, aged eighty, at Southsea, seen with Mr. Potts and Sir W. Gull. After a chill there was a period of ten days marked by irregular pyrexia, malaise, and hurried breathing. On the eleventh and twelfth day slight friction was heard below the angle of the right scapula, followed by dulness and tubular breathing. The patient recovered. A third case was one he saw with Dr. Buzzard, when the patient had been ill for six days with pyrexia without any local signs. He did not think it necessary to have all the physical signs present to diagnose pneumonia; and that in case of central pneumonia the disease was too far removed from the surface to yield these signs. With a history of chill, with distress and prostration, with fever, and a disturbed relation between pulse and respiration, one may be absolutely certain that the case is one of pneumonia.—Dr. Habershon concurred that in some cases the general symptoms, with hurried breathing and rusty expectoration, without physical signs, may be taken as sufficient for diagnosis. No doubt such anomalies were explained by the disease being deep-seated, so that the physical

signs are obscured, just as a severe pleurisy may involve the surface of the diaphragm without any friction being audible. When the physical signs do become manifest the pneumonia has probably extended to the periphery.—Dr. Andrew Clark added that pneumonia might be diagnosed from the general conditions; because in a large number of cases there is neither cough, nor expectoration, nor pain in the side.—Dr. De H. Hall, some five or six years ago, had recorded two cases of apical pneumonia marked by severe head symptoms. One was a man, aged nineteen, who was comatose for six hours; the other a child, who had repeated convulsions; and it was only on the fifth or sixth day that distinct tubular breathing appeared. One reason for the severity of these cases, as compared with those which ran a more typical course, might be found in the greater amount of lung involved in central peripheral pneumonia.—Dr. Burney Yeo said that such cases suggested the question whether the lung condition was not secondary to a constitutional disorder.—Dr. Goodhart observed that the question was a complicated one, so many conditions concurring under which the physical signs varied. In old people the late appearance of these signs was attributable to the presence of emphysema. At the same time he agreed with Dr. Yeo that blood-poisoning might be the primary condition to which the pneumonia was secondary. Some years ago he examined the body of an old man, who died three or four days after taking a chill. There was only a slight amount of pneumonia, and the only interpretation he could put on the case was that the chill, arresting the function of the skin, had caused blood-poisoning and that sufficient time had not elapsed for true pneumonia to be fully developed.—Mr. Tyson replied, that all his cases ultimately developed the signs of ordinary pneumonia. The last case he had seen was in a child, five years of age, with high temperature for six days, without pneumonic symptoms. He had written the paper because all the authorities he had consulted did not mention the proportion of cases in which this delay in the development of physical signs occurs; although many state that they have seen such cases.—*The Lancet*.

## ON THE ACTION OF DISINFECTANTS ON SEWAGE AND THE LIVING OR- GANISMS CONTAINED THEREIN.

BY JOHN TRIPE, M.D.

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The experiments were made at different times, but each set carried out simultaneously, and therefore comparable. Carbolic acid No. 5: When mixed in the proportion of 2 per cent. all smell was removed and all living organisms destroyed. As long as twenty-one days afterwards there was no return of smell or bacterial life. When ten parts of carbolic acid were added to a mixture of sewage and beef, the infusoria but not the bacteria were destroyed and the smell removed. With Burnett's fluid, mixed in the proportion of 2 per cent., the same result followed as in carbolic acid. In the other proportion the effect was less marked. Euchlorine, when added to sewage in the proportion of 2 per cent., removed offensive smell and destroyed infusoria. In the second set of experiments with the sewage and beef solution a mixture of 10 parts to 4000 had but little effect. With sporokton, added in the proportion of 2 per cent., no living organism was detected. In the second experiment the smell was but little altered by a strength of 10 parts in 4000 of the sewage and beef mixture; but when the sporokton was increased in strength to one in 300 the infusoria died, but the bacteria were as active as ever. Solution of chlorine (P.B.) and solution of chlorinated lime (P.B.) did not appear to have much action. Chloralum, when added in the proportion of 10 to 4000, did not immediately affect the smell; but on the second day there were fewer living organisms than in any other solution, except in those of carbolic and hydro-chloric acid, and Burnett's fluid. Condry's fluid, when added in the proportion of twenty parts in 4000 completely failed to remove smell or destroy infusoria. In the proportion of one in 50 the offensive smell was removed, and the movement of the bacterium termo was stopped. Sanitas: The addition of 10 to 2000 of sewage and beef produced but little alteration in the smell. With one per cent. of sanitas the smell was much abated, but the living organisms were more abundant than even in the Condry's fluid of the same strength. Sanitas powder was more energetic in its action than sanitas fluid.—*London Lancet*.



## TREATMENT OF MEMBRANOUS SORE THROAT.

—At a recent meeting of the Academy of Medicine of Paris, Dr. Viard made a communication on this subject. He considers that membranous sore throat is primarily a local affection, which does not become general for five or six days; during the first period the diphtheria may be cured by cauterization (*Medical Press and Circular*). During the last eighteen months he had twenty-six cures out of twenty-eight cases. Wrapping his finger in a rough cloth he removes the false membrane, leaving in its place a bleeding surface; then he cauterizes with nitrate of silver; four or five such cauterizations neutralize the diphtheritic poison. General tonic treatment is employed at the same time.—*Chicago Medical Journal and Examiner*.

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### Surgery.

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COPAIVA IN SCIATICA.—Dr. H. C. Marsh writes to the *London Medical Times and Gazette*, of copaiva:—I wish to speak of this drug as wonderfully efficacious in sciatica. (After describing a most obstinate case he stated) at last I prescribed

R. Bals. copaib.,	ʒiv
Tr. lavand.,	ʒiv
Tr. hyos.,	ʒiij
Pot. bicarb.,	ʒj
Mucilag.,	ʒj
Aquæ,	ʒvj M.

A tablespoonful every four hours.—*Medical and Surgical Reporter*.

## IMPROVED STYPTIC.—

Collodion.....	100 parts.
Carbolic acid .....	10 "
Tannin.....	5 "
Benzoic acid (from the gum)	5 "

Mix the ingredients in the order above written until perfect solution is effected. This preparation has a brown colour, and leaves, on evaporation, a strongly adherent pellicle. It instantly coagulates blood, forming a consistent clot, and a wound rapidly cicatrises under its protection.

SPINA BIFIDA TREATED WITH PLASTER OF PARIS.—Dr. Lewis A. Sayre, in a clinical lecture, says that the object of mechanical treatment is simply to protect the parts from all pressure and all possible injury until the process of ossification is completed throughout the entire length of the spinal column. This he accomplishes by first slipping over the trunk a tightly-fitting knit shirt, similar to that used in applying the plaster jacket in Pott's disease, or lateral curvature. Then, having the patient held in a firm position, but without being suspended, he passes a few turns of a plaster bandage around the trunk and pelvis in such a manner as to cover the spina bifida completely. After this he cuts off a piece from both the top and bottom of the shirt, and turns the remaining portions over the part covered with plaster. He then makes a few more turns of the plaster bandage outside of all, and finally, before the plaster has had time to set, presses in the plaster with the hands on both sides of the tumor, so as to make the covering more cup-shaped, and thus protect it the more completely from all pressure. He thus makes a hard, artificial roof for the spinal cord and nerves, which takes the place of the normal bony one until nature supplies the deficiency. If, on account of the child's growth, other similar plaster casings are required, they can be supplied in the same manner.—*Journal of Materia Medica*.—*Chicago Medical Journal and Examiner*.

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### Midwifery.

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REMARKABLE CASE OF EARLY MATERNITY.—Mr. Henry Dodd, M.R.C.S. Eng., &c., of Rillington, York, writes to the *London Lancet*, that on the 8th of August, 1871, he delivered a joiner's wife of a female child. The babe began to menstruate when 12 months old, at first at intervals of a month or six weeks and subsequently every three weeks. According to the mother's statement she ceased menstruating on the 22nd of June, 1880, when she became pregnant. She is an active, hard-working girl, doing all her mother's washing. She has a profuse hirsute growth over pubes and in axilla, and the breasts are large and gorged with milk. In March Mr. Dodd delivered her of a female child weighing 7lbs. Chloroform was administered, and the labour lasted six hours. The child had only three toes on the left foot; and sometime after birth died of convulsions. The youthful mother is now nine years and eight months old.

## Translations.

### CAUSES OF HUMMING IN THE EARS.

M. Boudet, of Paris, concludes from his researches on this subject. 1st. Amongst the causes of humming of the ears it is suitable to take into account the increase of the muscular bruit by a resonant cavity. 2nd. The formation of this resonant cavity is obtained pathologically or experimentally by the occlusion of one of the natural cavities of the auditory apparatus, that is to say, by obstruction of the external conduit of the Eustachian tube.—*L'Union Médicale*.

### VASELINE AND LEAD OINTMENT IN SQUAMOUS DERMATOSES.—(KAPOSI.)

Simple lead-plaster, 30 grammes, vaseline 30 grammes. Melt together at a gentle heat, remove while cooking, and perfume with one gramme of essence of bergamot or lavender or with balsam of Peru. The author recommends this ointment to detach the crusts and scales in certain dermatoses, and in particular in eczema squamosum, when the skin is dry and covered with epidermic lamellae. Even on excoriated surfaces it gives rise to no sensation of burning. It is preferable to Hebra's ointment as it is inodorous and does not change when applied to the skin.—*L'Union Médicale*.

### TREATMENT OF TYPHOID BY SALICYLATE OF SODA AND QUININE.

Dr. Hallopeau, in a memoir read before the Medical Society of the Hospitals, upon the treatment of typhoid by salicylate of soda and quinine, concludes as follows:

Having arrived at the termination of this study we will gather the information which appears to us to arise from our own observations and from those that have been published elsewhere, in the following propositions:

1. The salicylate of soda and the sulphate of quinine ordinarily exercise a notable action on the temperature of typhoid.

2. The action of the salicylate of soda is not usually continuous; at the end of two or three

days, even when new doses are administered, we see new ascensions of the thermometric curve, they now as a rule, attain only passingly the initial figures and the centre of the thermic oscillations remains generally lowered.

3. Two grammes of salicylate of soda suffice usually to produce an anti-pyretic action.

4. In the dose of four grammes and over, this medicine seems able to give rise by itself to accidents and particularly to exaggerate the dyspnoea, increase the pulmonary congestion, favour the tendency to hæmorrhages and sometimes to provoke delirium and agitation.

5. These accidents may be avoided if the salicylate of soda be given in the dose of two grammes only, and if we abstain from prescribing it more than three days consecutively, and if we have due regard to the contra-indications.

6. These contra-indications are above all thoracic complications, grave cerebral accidents and hæmorrhages.

7. In prescribing alternately sulphate of quinine and salicylate of soda, we succeed most often in maintaining the centre of the thermic oscillations at a relatively low figure; we thus avoid the pernicious effects of the hyperthermy and it seems that we exercise at the same time a favourable action on the evolution of the disease, we act upon the temperature as powerfully as with the cold bath without exposing the patients to the same accidents.

8. The anti-pyretic action of the sulphate of quinine is produced at the very time that that of the salicylate of soda seems to be exhausted and reciprocally, their therapeutic effects are increased, but not their toxic effects.

9. At the same as the internal anti-pyretics we may advantageously employ, as accessory means, cold lotions, cold applications to the belly and cold clysters.

10. In cases in which the hyperpyrexia persists in spite of this medication we may carry the daily doses of sulphate of quinine to  $1\frac{1}{2}$  grammes, 2 grammes and even 3 grammes. We may equally give 4 grammes of salicylate of soda on condition of renewing this dose only every two or three days, and after having found by examination of the urine that the medicine has been eliminated.—*L'Union Médicale*.



## Correspondence.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

SIR.—Will you be good enough to give me space in the Journal for the following, for which I shall be much obliged :

I am desirous of making some investigations into the causes of that most destructive disease, pulmonary phthisis ; and any members of the profession in the Dominion who have now on hand well marked cases of this disease will confer a favour, and may possibly advance the interests of science, by sending me their address on a post card, when I will send them a list of questions which they can readily answer, with a view of obtaining a full history of the cases for study.

I trust your readers will see the importance of this work, and will kindly take a little trouble and aid me in this way in the investigations, and that we may all be benefitted thereby.

I am, sir, yours, &c.,

EDWARD PLAYTER.

Toronto, April 20th, 1881.

POTTED MEAT.—Dr. Fergus reports in the *London Lancet* some cases of poisoning from the use of potted meats, (salmon, lobster, etc.) The *Huddersfield* (England) *Examiner*, gives alarming reports concerning one of these manufactories. Diseased meats of various kinds, mutton, beef, and even horse-flesh, were found in the course of preparation. Sausages were made from strange and very unwholesome materials, and coloured with red ochre. These facts should make us very cautious about the use of potted meats. Although we think the salmon, mackerel, etc., of this country, so prepared, are, as a rule, above any suspicion of such dangers. We must always look on the meats with dread, as, apart from the criminal procedure of using diseased materials, there is always a great temptation to use inferior qualities.

On the 9th of April there were 1,510 medical graduates for 1881 in the United States, with several colleges not heard from.

THE CANADIAN  
*Journal of Medical Science,*

A Monthly Journal of Medical Science, Criticism,  
and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations*

TORONTO, MAY, 1881.

THE PHYSICIAN AND THE  
DRUGGIST.

The following advertisement appeared in one of the Brantford newspapers :

"Dombey & Co's. New Drug Store. O'Reilly's Hair Restorer.

"This preparation is, compounded from the original formula of Dr. O'Reilly, Resident Physician of Toronto General Hospital, and is a decided promoter of the growth of the hair."

\* \* \* \* \*

It was a source of considerable surprise to Dr. O'Reilly to find himself thus suddenly announced as the benefactor of the Brantford baldheads, and he at once put the matter in the hands of a lawyer, who telegraphed, and wrote to this *enterprising* firm, ordering them to withdraw all advertisements, and destroy all labels, &c., containing the name of Dr. O'Reilly, and at the same time to send an apology forthwith. In reply the following letter was received :

Brantford, Canada, April, 1881.

This is to certify that we, Pilkey & Co., Druggists of the City of Brantford, Canada, used the name of Dr. O'Reilly, Medical Superintendent of the Toronto General Hospital, in the advertisement annexed hereto, without his knowledge, privity, or consent, and we undertake to forthwith stop the publication of the said, or similar advertisements, and to at once discontinue the use of his name in connection with any such compounds, or otherwise, howsoever, and we hereby apologize for our unwarranted use of his name.

(Signed) A. E. DOMBEY & Co.

(Signed)

Witness—AUGUSTINE D. FARR.

Physicians in this, as well as in other countries, have often had occasion to complain of the actions of druggists in making use of their prescriptions for their own private gain, after they had made their legitimate profit on the medicine at the proper time. The above case is one of the most flagrant violations of trust on the part of the dispenser that we have heard of. A prescription of Dr. O'Reilly's was brought to a well known drug store in Toronto and properly dispensed. After a time the dispenser left Toronto, and his services were secured by the "Pilkey" firm, of Brantford. Being a brilliant genius, he conceived the happy idea of making use of some of his Toronto prescriptions, and the result of his first attempt was "O'Reilly's Hair Restorer." The Dr. by his prompt action put rather a sudden stop to this piece of extraordinary impertinence, to say the least of it, and we hope it will be a valuable lesson to druggists in general, as we fear, that in some localities especially, the physicians have just cause to complain of the acts of those who dispense their medicines.

### THE MODEL HOSPITAL.

The following allegory has been sent us by a gentleman who has had a wide experience of "men and cities," but who, for special reasons, desires to remain *incog*. The exigencies of space have required us to abscind the seemingly less essential portion of the manuscript, and we have taken the liberty to suppress one or two expressions which might offend where no offence was meant. The remainder we commend to the thoughtful consideration of our Hospital authorities as containing suggestions calculated to promote an object which we know them to have very much at heart: the highest efficiency and the widest utility of the eleemosynary trust committed to them.

"Among the newest discoveries has been that of a city in the desert of Sahara. Here, beneath this waste of sand, in this most barren of all lands, have been found the ruins of the once flourishing city of Otnorot, destroyed, it is supposed, by the sudden rising of the waters of the lake Oiratno, on whose shores it was built. It

was famed for its 'Model Hospital,' an institution which had a small beginning, which was the incubator of many an acrimonious quarrel and party struggle, but which at length attained, through its dearly bought experience, a place in the foremost rank. Having obtained some scraps of its history, from papers recently disinterred from the ruins, I thought that they might prove of use and interest to some of your readers.

In the 'Model Hospital's' immediate neighbourhood flourished two medical schools, the Otnorot and Ytinirt, famed for their bitter hates and party jealousies. Neither took any interest in anything concerning the Hospital, and seemed (human nature to this day) chiefly interested, and were, perhaps, entirely interested, in the financial success of their individual undertakings. A rich man died, his will was disputed, and the property came into the government coffer. This body used part of it to found an eye and ear department in connection with the Hospital. A wealthy firm made a grant of funds to erect a building to be used specially for the treatment of fevers. A splendid laundry and a small morgue were also built. A new building was erected for a lying-in-hospital, and the building formerly used for that purpose was turned into a club. It was customary in those days, among the savage nations, to have, what we would call, a medical superintendent in their hospitals, who was well paid; but, under this all-supreme head were several poor assistants who did a large share of the work, and in payment received their board free. They did not mind this, because the experience they were gaining was invaluable; but when money seemed so plentiful, a little would have agreed with them admirably. The assistants took entire charge, while their superior visited the sister institutions at Tangiers, Algiers and Tunis; he went away to imbibe any new ideas and to enjoy life. As the matron and assistant matron were not supposed capable of imbibing new ideas they had a week or two for a holiday in the summer to recruit their health, injured by a year of toil; their toil was meanly paid with a miserly pittance, because it was the toil of women; what else could we expect among the heathen



where it is customary to make the women work while the men receive the pay? Then, too, the managers were too prone to look upon the Hospital as a place solely for the care of patients, and to forget the duty of teaching students to whom, as the medical practitioners of the future, the lives of their children and their grand-children must be entrusted.

At this Hospital, it was a rule that members of the visiting staff could not resign until they had served for at least thirty years; as a consequence, young men received no encouragement to work hard, and a sad lack of enthusiasm pervaded the clinics. The old 'fogies' were often unable to attend on their appointed days, owing to a severe attack of rheumatism, or, because they could not miss the chance of performing a certain operation, for which they were to be handsomely paid. These old men were so occupied with private practice that they had no time to read any new pamphlets, which were written in those days, not printed. If, in the hospital, a student, more eager than his fellows, wished, from personal observation, to learn what his teachers would not take the time to teach him, he was prevented from doing so by the rule that "no student is allowed in the wards unless accompanied by some member of the staff," for fear that he might disturb the homelike quiet of the ward, or the day dream of some nursing of charity.

But at last a change came. The young men did not try, for it was a sore trial, they did not try to study medicine at home, but went abroad where hospitals were conducted differently. They returned home with the new ideas, and, reasoning as they did, any one unprejudiced must have coincided with them in their arguments. Every one was convinced, and even the impressionable trustees saw their faults and began to remedy them. The result was the formation of the 'Model Hospital' and 'the Hospital Medical School.' The rule about the thirty years of service was changed and no one was allowed to remain on the acting staff for more than ten years. The old 'fogies' were shelved on the consulting staff, and deserving eligible young men were put in their places. These young men had been promised the posi-

tions and had gone abroad for several years to fit themselves for them. A physiological laboratory, a pathological laboratory and a chemical laboratory were built, and the university professors, in the several branches, conducted these institutions. All members of the hospital staff were nominally professors of the university of Otnorot. The staff of the General Hospital was composed as follows:—

## DAYS OF CLINIC.

1st. Physician.....	} Mondays & Thursdays.
1st. Asst. Physician..	
2nd. Physician.....	} Tuesdays & Fridays.
2nd. Asst. Physician..	
3rd. Physician.....	} Wednesdays & Saturdays.
3rd. Asst. Physician..	

The assistant physicians conducted the outpatient clinics, on their respective days, at 12.30; and any specially interesting or doubtful cases were sent up to the physician of the day, whose clinic began at 2 o'clock. Either before or after his clinic, the students accompanied the physician through the wards. His house physician and clinical clerks also accompanied him, and were constantly subjected to examination at the bedside. The history of each patient's illness hung at the head of his bed; it was the duty of the clinical clerk to write these, and they were filed when the patient succumbed or was discharged. No one was appointed physician without having been assistant physician, assistant physicians must have been house physician, house physicians must have served as clinical clerks for nine months, three terms of three months under three members of the staff. The number of clinical clerks was regulated according to the number of students. Each student, before being eligible for examination, had to serve for nine months as clinical clerk as in the case of house physicians. No salaries were paid to any of the medical assistants or house physicians.

Each house physician was master of his own department, and could only be reprimanded by the visiting trustee or by the board for any offence he committed. The matron, steward and secretary, were also guided by the trustees to whom they had to account for their actions; but each member of the working staff tried to carry out any feasible suggestion made by any

other member, and all tried to work harmoniously together.

In the lying-in-hospital two clinics were given weekly in the wards and two out-door gynaecological clinics. The staff of this institution consisted of two gynaecologists and a resident accoucheur.

1st. Gynaecologist..... } Monday, in-door at 11 a.m.  
Thursday, out-door at 10.  
2nd. " ..... } Tuesday, out-door at 11 a.m.  
Friday, in-door at 10.

Two maternity assistants resided in the hospital; as soon as one had attended six cases another took his place. Outside obstetric work could also be had by applying to the resident accoucheur. The resident accoucheur was chosen

from the house physicians, and appointed for one year.

In the eye and ear department, the appointments were similar to those of the lying-in-hospital, viz., two oculists, with an in and out-door clinic per week, each, and one resident house oculist.

Each physician had a 'take in' week, beginning with physician No. 1. During this period, his clinical clerks and the clerk of his assistant physician lived, two at a time, in the hospital, beginning at 4 o'clock on Friday afternoon, and continuing until the following Friday at the same hour. They came in their regular rotation, as can be seen from the following plan:—

MEMBER OF STAFF.	HOUSE PHYSICIANS.	CLERK.	TAKES IN.
Dr. A., Physician. Dr. A. X., Assistant Physician.	Dr. ———.	1. Mr. ———. 2. Mr. ———. 3. Mr. ———.	January 1-7 ..... { 1. Mr. ———. 2. Mr. ———. January 21-28 ..... { 2. Mr. ———. 3. Mr. ———. February 11-18 ..... { 3. Mr. ———. 1. Mr. ———. March 4-11 ..... { 1. Mr. ———. 2. Mr. ———.
Dr. B., Physician. Dr. B. X., Assistant Physician.	Dr. ———.	1. Mr. ———. 2. Mr. ———. 3. Mr. ———.	January 7-14 ..... { 1. Mr. ———. 2. Mr. ———. January 28-February 4 .... { 2. Mr. ———. 3. Mr. ———. February 18-25 ..... { 3. Mr. ———. 1. Mr. ———. March 11-18 ..... { 1. Mr. ———. 2. Mr. ———.
Dr. C., Physician. Dr. C. X., Assistant Physician.	Dr. ———.	1. Mr. ———. 2. Mr. ———. 3. Mr. ———.	January 14-21 ..... { 1. Mr. ———. 2. Mr. ———. February 4-11 ..... { 2. Mr. ———. 3. Mr. ———. February 25-March 4 ..... { 3. Mr. ———. 1. Mr. ———. March 18-25 ..... { 1. Mr. ———. 2. Mr. ———.

The above plan was for three months. The clerks were on duty in the receiving room where patients, wishing admission into the hospital or any 'accident cases,' were seen. Here a diagnosis was made by the clerks, confirmed or refuted by the house physician, and then the patient sent to the proper ward. If urgently requiring any major operation, the physician of the week was sent for, except between the

hours of 10 p.m. and 5 a.m., when the assistant was summoned. If requiring a minor operation, as amputation below the elbow or knee, the assistant physician of the week was sent for.

All *post-mortem* examinations were conducted by the professor of pathology and pathological anatomy, in his laboratory near by. Lessons in microscopy were here given, although this in-



strument seems to have entirely disappeared later on, but within the last (?) hundred years has been, so to speak, re-invented. A wealthy citizen presented the institution with twenty-five of these instruments for the use of the students, so that every facility for the practical teaching and study of this all-important branch was given. Long rows of tables were provided for the use of the class as well as mounting fluids. Each was furnished with a locked and numbered box for the instrument lent him; for all of these he was held responsible.

A dispenser for the hospital was appointed every six months, from among the students at the chemical laboratory. He received a small salary as the work was arduous.

The medical school in connection with the hospital was a great success. The rival institutions soon closed their doors, and freely acknowledged that there was in Otnorot only enough talent to conduct one good school. The young lecturers in the new school were all trained abroad, each for his special branch. Lectures on chemistry and physiology were given in their respective laboratories. Anatomical lectures, pathological lectures were given, and dissections were made in the pathological laboratory. If a vacancy from any cause seemed probable, a young man was led to believe that if he went abroad and prepared himself he might obtain it. Acting on this he started for some foreign university. Thus a good school was kept up, so much so that finally one could study better at Otnorot than in cultured and civilized Europe. None of the medical assistants received any salary, and none wished for any; yet, there was always a surplus of candidates for office. The matron's salary was increased, as was her assistant's. The hospital was considered perfect in every respect, and well deserved the world-wide reputation the 'Model Hospital' obtained."

ERRATUM.—In the formulæ for treatment of eczema on the last page of our last issue for "carmin" read "tannin."

CORRESPONDENCE.—X. Y. Z. has forgotten to enclose his card.

## UNIVERSITY SENATE ELECTIONS.

We have to remind our readers that the Voting Papers must be delivered to the Registrar before noon on the 4th of May. If any, therefore, have neglected the matter, they should at once put in the names of Mr. Taylor, Dr. McFarlane, and Mr. Falconbridge, and forward their papers as directed by Mr. Baker.

We hear with grief of a "ring." A ring is a terrible thing—a round thing, that has no end; but a change is coming, however, as the anti-ringers intend to annihilate it. The intention, under the new regime, is to make one half the Graduates members of the Senate, and the other half University Examiners. Perhaps, it is only simple justice to give all "the boys" a chance.

## MEDICAL EXAMINATIONS IN TORONTO UNIVERSITY.

It gives us great pleasure to note a new feature this year in the method of conducting these examinations. The candidates for the "third year" were examined practically in the General Hospital in medicine and surgery by the respective examiners, Drs. Eccles and Malloch. The results were very satisfactory, as they were sure to be under a physician and surgeon so well qualified to conduct a practical examination in these subjects. The Medical Superintendent, Dr. O'Reilly, with his usual courtesy, gave the examiners every assistance in his power, and placed all the material in the Hospital at their disposal.

THE ONTARIO MEDICAL ASSOCIATION.—We desire to direct the attention of our readers to the official announcement of the first meeting of this Association which appears on our last (cover) page. We are happy to say that the promoters of this organization have received the strongest encouragement from all sections of the Province, with one exception, and there is every prospect of a most successful meeting on the first of June.

The annual meeting of the Ontario Medical Council will take place on the second Tuesday in June, (the 14th).

UNIVERSITY OF MCGILL.—*Faculty of Medicine*.—The total number of students enregistered in this Faculty during the past year was 168, of whom there were, from Ontario, 79; Quebec, 48; Nova Scotia, 5; Manitoba, 1; New Brunswick, 9; P. E. Island, 5; Newfoundland, 1; West Indies, 1; and the United States, 19. The following gentlemen, 36 in number, have passed their Primary Examination on the following subjects: Anatomy, Practical Anatomy, Chemistry, Practical Chemistry, Materia Medica and Pharmacy, Institutes of Medicine and Botany or Zoology. Their names and residences are as follows:—Clarence E. Allen, East Farnham, Q.; Edson C. Bangs, Faribault, Minn.; S. A. Bonesteel, Columbus, Neb.; James C. Bowser, Kingston, N. B.; C. O. Brown, Lawrenceville, Q.; C. E. Cameron, Montreal, Q.; J. W. Cameron, Montreal, Q.; Angus M. Cattenach, Dalhousie Mills, O.; H. J. Clarke, Pembina, Dakota; W. C. Cousins, Ottawa, O.; W. J. Derby, North Plantagenet, O.; George A. Deardan, Richmond, Q.; J. J. Gardner, Beauharnois, Q.; James A. Grant, B.A., Ottawa, O.; James Gray, Brucefield, O.; Chas. B. H. Hanvey, Cleveland, Ohio; Joseph A. Hopkins, Cookshire, Q.; J. H. Harrison, Moulinette, O.; Robert J. B. Howard, B.A., Montreal, Q.; W. D. Brydone Jack, B.A., Fredericton, N. B.; P. N. Kelly, Rochester, Minn.; John S. Lathern, Yarmouth, N. S.; J. B. Loring, Sherbrooke, Q.; Robert K. McCorkill, Montreal, Q.; Wm. J. Musgrove, West Winchester, O.; Floyd S. Muckey, Medford, Minn.; T. Pierce O'Brien, Worcester, Mass.; T. A. Page, Brockville, O.; Allen P. Poaps, Osnabrock Centre, O.; And. J. Rutledge, Bayfield, O.; Clarendon Rutherford, M.A., Waddington, N.Y.; Walter McE. Scott, Winnipeg, Man.; George A. Sihler, Simcoe, O.; E. W. Smith, B.A., New Haven, Conn.; Andrew Stewart, Howick, Q.; and W. E. Thompson, Harbour Grace, Nfld. The following gentlemen, 38 in number, have fulfilled all the requirements to entitle them to a degree of M.D., C.M., from the University. These exercises consist in examinations, both written and oral, on the following subjects: Principles and Practice of Surgery, Theory and Practice of Medicine, Obstetrics and Diseases of Women

and Children, Medical Jurisprudence and Hygiene,—and also Clinical Examinations in Medicine and Surgery conducted at the bedside in the Hospital:—S. A. Bonesteel, Columbus, Neb.; T. L. Brown, Ottawa, O.; Paul Cameron, Lancaster, O.; J. H. Carson, Port Hope, O.; W. Cormack, Guelph, O.; H. C. Feader, Iroquois, O.; H. D. Fraser, Pembroke, O.; E. C. Fielde, Prescott, O.; W. L. Grey, Pembroke, O.; C. M. Gordon, Ottawa, O.; J. B. Harvie, Ottawa, O.; H. E. Heyd, Brantford, O.; H. A. Higginson, L'Orignal, O.; D. W. Houston, Belleville, O.; J. J. Hunt, London, O.; G. E. Josephs, Pembroke, O.; W. A. Lang, St. Mary's, O.; E. J. Laurin, Montreal, Q.; Henry Lunam, B.A., Wakefield, Q.; R. T. Macdonald, Montreal, Q.; E. A. McGannon, Prescott, O.; Kenneth McKenzie, Richmond, Q.; Frank H. Mewburn, Drummondville, O.; W. Moore, Owen Sound, O.; W. C. Perks, Port Hope, O.; T. W. Reynolds, Brockville, O.; E. J. Rogers, Peterboro', O.; James Ross, B.A., Dewittville, Q.; J. W. Ross, Winthrop, O.; T. W. Serviss, Iroquois, O.; J. C. Shanks, Huntingdon, Q.; W. A. Shufelt, Brome, Q.; E. H. Smith, Montreal, Q.; W. Stephen, Montreal, Q.; A. D. Struthers, Philipsburg, Q.; J. E. Trueman, B.A., Woodstock, N.B.; G. C. Wagner, Dickinson's Landing, O.; and J. Williams, London, O. Of the above named gentlemen, W. Cormack is under age. He has, however, passed all the examinations, and fulfilled all the requirements necessary for graduation, and only awaits his majority to receive his degree. Mr. H. A. Higginson, of L'Orignal, has been taken ill since the examination, and is consequently unable to present himself. Messrs. James Ross, E. J. Laurin, K. McKenzie, and A. D. Struthers, natives of the Province of Quebec, have fulfilled all the requirements for graduation, but await the completion of four years from the date of passing the matriculation before receiving the degree. *Medals, Prizes and Honours*.—The Holmes Gold Medal for the best Examination in the Primary and Final Branches was awarded to James Ross, B.A., Dewittville, Q. The Prizes for the best Final Examination was awarded to J. L. Ross, of Winthrop, Ont. The Gold Medallist is not permitted to compete for



this prize. The Prize for the best Primary Examination was awarded to R. J. B. Howard, B.A., of Montreal. The Sutherland Gold Medal was awarded to C. E. Cameron, of Montreal. The following gentlemen, arranged in the order of merit, deserve honourable mention:—In the Final Examination, Messrs. Perks, Heyd, Laurin, Josephs, Grey, Shufelt and Rogers. In the Primary Examination, C. E. Cameron, W. L. Lathern, W. McE. Scott, and J. J. Gardner. *Professors' Prizes*:—Botany.—First Prize, G. A. Graham, of Hamilton, Ont., and E. Gooding, of Barbadoes, W. I., equal. For the best Collection of Plants, J. C. McRae, of Port Colborne, O., and J. J. Meahan, of Bathurst, N.B. Practical Anatomy.—Demonstrator's Prize, awarded to C. E. Cameron, of Montreal.

**SUMMER COURSE OF LECTURES.**—Through the consideration of the indefatigable Secretary, Prof. Wm. Osler, M.D., we are in receipt of the programme of the Summer Course of Clinical and Didactic Lectures to be delivered between April and July in McGill College, Montreal. We very much regret that our Toronto Schools do not see their way clear to the establishment of such a course.

**VICTORIA UNIVERSITY.**—At a recent examination, the following gentlemen having passed successfully, were recommended for the M. D. viz., W. H. Aikins, W. C. Edmonson, F. Howett, A. C. Jones, M. Wallace, G. S. Bingham, R. R. Tellor, M. A. Nicholson, L. M. Sweetnam, W. Gunn, J. G. Mennie, R. M. Fisher, H. W. Aikins, H. R. Elliott, S. A. Bosanko, A. G. Machell, G. Wilcok, W. J. Tracy, W. A. D. Montgomery, W. J. Charlton, G. W. Haker, A. Chapman, J. C. Burt, J. McBride, J. M. Cotton, J. Simpson, W. Gilpin, R. S. Frost, E. A. Nealon, H. Y. Baldwin. The following also passed the primary examination, viz., R. B. Coulter, W. H. Montague, W. Cuthbertson, H. P. Jackson, M. R. Collver, E. Laws, Geo. Wyld, J. Z. Wyld, W. J. Kellow, R. J. Burton, C. S. Grafton, J. W. Wilmott, J. B. Whitely, F. P. Drake, M. R. Elliott, G. W. Clendenning, A. D. Watson, E. M. Hewish, C. I. Wilson, J. F. Carroll.

## OBITUARY.

Probably few physicians were better known in Ontario, than Dr. William Mostyn, of Almonte, whose sudden death by drowning on the 30th of March caused such a shock to his many friends. He graduated at Queen's College University, Kingston, in 1858, and since that time had been practising at Almonte. He always took a leading position in the district of the "Ottawa Valley" in matters political, medical, and otherwise. He, for a time sat as member in the Local Legislature, and at the time of his death, was President of the Agricultural Society in Lanark, and was also a member of the Ontario Medical Council.

Being a man of good ability, of high professional attainments, of a kind and genial disposition, liked by all who came in contact with him, beloved by his intimate friends, his memory will long be cherished with the fondest recollections.

The funeral took place on the 2nd of April, under the auspices of the Freemasons. According to the *Kingston Daily News*, there were between 4,000 and 5,000 present. Drs. Sweetland and Bentley, of Ottawa, Sullivan, of Kingston, Woodford, of Brockville, Lynch and Patterson, of Almonte, and Baird, of Pakenham, acted as pall-bearers. The remains were brought to Kingston, and buried in the Cataraqui Cemetery.

A vacancy is created in the Ontario Medical Council in consequence of the resignation of Dr. Irwin, who represented the Quinte and Cataraqui Division. The Dr. resigned on account of his appointment to the Chair of Medical Jurisprudence in the College of Physicians and Surgeons of Kingston.

We understand that Dr. Day, of Trenton, and Dr. Tracy, of Belleville, are candidates for election. Dr. Day was the representative of this division from '69 to '72, and as such was one of the most able and faithful members of the Council. He was a candidate at the last election, but was defeated by the casting vote of the Returning Officer. We hope there will be no doubt about his election.

The names of Dr. J. D. Killock, of Perth, and Dr. J. G. Cranston, of Arnprior, have been mentioned as candidates in the Rideau and Bathurst division, to fill the vacancy in the Medical Council, caused by the death of Dr. Mostyn.

The Election of Representatives for the Quinte and Cataraqui, and the Rideau and Bathurst divisions, in the Ontario Medical Council, will take place on the 17th of May. The voting papers will be issued by the Registrar on the 2nd.

**MEDICAL EXAMINATIONS—LIST OF THE SUCCESSFUL KINGSTON GRADUATES.**—The following have graduated from the Royal College of Physicians and Surgeons:—Without an oral—W. J. Gibson, Kingston; J. L. McGuern, Lonsdale; D. Wallace, North Graves; E. Oldham, Kingston; James F. O'Shea, Norwood; M. Dupuis, Kingston; F. R. Alexander, Ottawa; A. W. Herrington, Mountain View; J. H. Betts, Portsmouth; D. Johnson, Consecon. With an oral—R. Coughlan, Hastings; John Jamieson, Kars; B. J. McConnell, Pembroke; D. H. Snider, Niagara; T. J. Symington, Camlachie.

**TRINITY MEDICAL SCHOOL.**—The following are the Medallists and Honour men in this school for 1881:—Final, W. A. Mearns, Gold Medallist; A. H. Ferguson, First Silver Medallist; W. F. Peters, Second Silver Medallist. Primary, Second year, W. J. Macdonald, Scholarship. Certificates of Honour, Wm. Bonnar, Wm. Bathass, L. Backus, A. D. Smith. First Year, W. Jenner, Scholarship.

Dr. Sheard, of this city, has, we learn, been appointed Professor of Physiology in Trinity Medical School.

**TORONTO SCHOOL OF MEDICINE.**—*Prizemen*—4th year, W. C. Edmondson, Orillia; 3rd year, J. T. Duncan, Goderich; 2nd year, W. J. Robinson, Fergus; 1st year, R. Hearn, Ottawa.

Dr. Graham, of Toronto, left home on the 15th of April, for a two-week's holiday, which he spent in New York and Philadelphia.

It was announced in our issue of December last, in consequence of changes in the proprietorship and management of this Journal, Mr. Joseph Heys had received for collection all accounts for subscriptions up to the end of 1880. We are requested by Mr. Heys to state, that, those who have not yet paid him, must do so at once. At the same time, we may say, that we (the present managers) are quite willing and ready to receive subscriptions for 1881.

The death of the late Earl of Beaconsfield, appears to have been due to gouty bronchitis. The English Medical Journals, condemn in no measured terms, Dr. Quain's consent to meet in consultation, at the bedside of the noble Earl, the well-known fashionable Homeopath, Dr. Kidd. If such things can be done in high places, it is useless to expect the principles of rational therapeutics and the dignity of scientific medicine to be upheld by the lesser lights.

We are glad to learn that the charge of extortion in the capacity of coroner, lately brought against Dr. Riddel of this city, and investigated at the last session of the Court of Oyer and Terminer, fell through on the Plaintiff's own evidence.

There was a meeting of the Executive Committee on the 31st of March. The time was occupied in receiving petitions of candidates, and making the arrangements for the examinations.

There were 1,900 Medical Students in New York during the past winter.

#### APPOINTMENTS.

Dr. Hope, of Belleville, has been appointed Sheriff of the County of Hastings.

Dr. Murphy has been appointed Physician to the Deaf and Dumb Institution of Belleville, *vice* Dr. Hope.

Dr. G. A. Routledge, of Lambeth, has been appointed an associate coroner for the County of Middlesex.

Warner E. Cornell, Esq., M.D., of the vil-



lage of Thedford, to be an associate coroner in and for the County of Lambton.

Dr. Yates, on account of removal from Kingston, has resigned his position in the Royal College of Physicians and Surgeons, and the following appointments have been made:—Dr. F. Fowler, Professor of Practice of Medicine; Dr. A. S. Oliver, *Materia Medica*; Dr. K. N. Fenwick, *Institutes of Medicine*; Dr. C. Irwin, of Wolfe Island, *Medical Jurisprudence*; Dr. C. H. Lavell, *Ophthalmic and Aural Surgery*.

### Book Notices.

*Failure of Vaccination.* By CARL SPINGER, M.D. (Reprint *St. Louis Clin. Record*.)

*Report of the Medical Superintendent of the Asylum for the Insane, Toronto, for the year ending Sept. 30th, 1880.*

*Physiology in Thought, Conduct and Relief.* By DANIEL CLARK, M.D., Medical Superintendent, Asylum for the Insane, Toronto. (Reprint from the *Canadian Monthly*.)

*Constitution and By-Laws of the American Academy of Medicine, as amended and adopted, September 17th, 1879, with list of members, officers and council for 1880-81.*

*On Quebracho Bark (Aspidosperma Quebracho).* Translated from the German. Illustrated by 25 Lithographic figures. Dr. ADOLPH HANSON of Erlangen. Geo. S. Davis, Publisher, Detroit. (Reprint from the *Therapeutic Gazette*.)

*Strangulated Veins of the Uterus, and other papers Gynecological and Surgical.* By THOS. H. BUCKLER, M.D., of Baltimore. (Reprint from *Boston Medical and Surgical Journal*.) Cambridge: Riverside Press. 1881.

*A Statistical Report of 252 Cases of Inebriety treated at the Inebriates' Home, Fort Hamilton, L.I.* By LEWIS D. MASON, M.D. A pamphlet of much interest to those engaged in the treatment and cure of dipsomaniacs.

*Two Cases of Extra Uterine Foetation with Results.* By CHAS. H. CARTER, B.A., M.D. Lond., M.R.C.P., Physician to the Hospital for Women, Soho Square. (Reprint from *Transactions of Obstetrical Society of London*.)

*Absence of the Vagina; Uterus distended by retained Menstrual Fluid, Operation, Recovery.* By CHAS. H. CARTER, B.A., M.D., Lond., M.R.C.P., Physician to the Hospital for Women (Reprint from *Obstetrical Society of London*.)

*The Heart and its Function.* New York: D. Appleton, & Co., 1, 3, and 5, Bond Street. 1881.

This is No. 8 of the English Series of Health Primers and comes, we assume, from the pen of Dr. Geo. W. Balfour; at all events it might have done so, and may be commended to the laity as a clear and intelligible account of the heart and its functions.

*Neues Schnellgefrier—Microtom.* VON DR. MED. Charles S. Roy, Cambridge, England.

This book is a reprint (illustrated) from the *Archiv. f. Mikroskop Anatomie*, pp. 19, containing an account of a new freezing microtome invented by Dr. Charles S. Roy, of Cambridge, England, which seems to answer the purpose of preparing instantaneous sections at the *post mortem* table, more satisfactorily than any other before the profession. The instrument is manufactured by the Cambridge Scientific Instrument Co., 18, Pantion Street, Cambridge.

*Transactions of the American Medical Association.* Vol. xxxi., 1881. Philadelphia: Collins, 705, Jayne Street.

The present volume, like many of its predecessors, while presenting an interesting account of the proceedings at its annual meeting, together with a number of very good and instructive papers, is remarkable for the absence of any really new and original contributions to the sum of scientific knowledge. Of course, no one can peruse the volume without experiencing much pleasure and no little profit; but at the same time we must admit that greater things might reasonably be expected of the

national Association of a great people—greater in nothing than its youthful attainments in the science and art of medicine. We entirely agree with Dr. Sayre, in his Presidential address, that it would be far better for the Association to inaugurate and publish such a weekly as the *British Medical Journal*, than to continue to issue "the present bulky, tardy, little read and unproductive volume of Transactions." This one idea we deem to be the most pregnant with profit in this edition.

*A Practical Treatise on Fractures and Dislocations.* By FRANK HASTINGS HAMILTON, A.M., M.D., LL.D. Sixth American edition, revised and improved. Illustrated with 352 wood-cuts. Philadelphia: Henry C. Lea's, Son & Co., 1880. Toronto: Hart & Rawlinson.

The appearance of the sixth edition of this work celebrates the attainment of its majority. In the 21 years which have elapsed since it first saw the light of day, no rival in the English language has arisen to divide or diminish the universal esteem or favour to which it at once attained. This fact alone speaks volumes for the manner in which it has supplied the wants of the profession and fulfilled its mission. Our foreign brethren, too, were not slow to recognize its merits; and by means of translations they now generally enjoy its use. Indeed, Malgaigne's classic, but now antiquated, work, is the only other complete treatise on the subject in any language. The noteworthy changes of the sixth edition are:—A Chapter on General Prognosis, a new account of Fractures of the Patella and a few minor substitutions and additions. To those who have not the work already we can only say that we marvel greatly, how the practical surgeon can be content to get along without it.

*A Text-Book of the Physiological Chemistry of the Animal Body, including an Account of the Chemical Changes occurring in disease.* By ARTHUR GAMGEE, M.D., F.R.S., Professor in Victoria University, Manchester; Brackenbury, Professor of Physiology in the Owen's College. Vol. I. London: Macmillan & Co. Toronto: Willing & William-son.

In this work chemistry is made subordinate to physiology and pathology, and for this reason it is of more practical interest and value

to the physiologist and physician than the title might lead one to suppose. In this volume the author takes up the elementary tissues of the body, including lymph and chyle. The chapters on blood are both scientific and exhaustive, not only in describing its physical characters and chemical composition under normal conditions, but also in discussing the changes which it undergoes in disease. The diseases, thus discussed, include 1st, various disorder of nutrition, such as anæmia, leucoeythæmia, purpura, rheumatism, &c.; 2nd, fevers; and finally, diseases of the heart, lungs, liver, kidney, and diabetes mellitus. In the chapters on the connective, contractile, and nervous tissues, we get the chemistry, histology, and physiology. The description of the contractile tissues is especially exhaustive and interesting. Although this volume is complete in itself, the author promises another during the year which will treat of the chemistry of the chief animal functions.

We can recommend this work without any reserve as being thoroughly scientific and at the same time highly practical. While the arrangement is good, and the subject matter everything that could be desired, the style is more pleasing and attractive than we had expected to find in such a book. It forms a happy connecting link between pure chemistry, on the one hand, and physiology and medicine, on the other. We hope it will be found in the hands of all our advanced students, and all our physicians who make any pretensions to combine in any degree the scientific with the practical.

*A Practical Treatise on Diseases of the Skin.* By LOUIS A. DUBRING, M.D. Second Edition. J. B. Lippincott & Co., Philadelphia, 1881.

The former edition of this work, published in 1876, was deservedly received with much favour by the profession on this continent. The present revised and enlarged edition is still more worthy of professional patronage.

A number of new articles have been inserted, treating principally of diseases which have been more fully investigated and described since the publication of the former volume. Many chapters have been enlarged, and important additions made to them. The work is thorough-



ly up to the times, nothing worthy of consideration in literature having escaped the notice of the author.

The book is remarkable for its completeness. In the description of disease and in the department of therapeutics, it is especially good. Perhaps the least satisfactory chapter is that on prurigo. In it the author adheres too closely to the description as it has been given by Hebra. This particular form of the disease, as it is frequently seen in Vienna, is so exceedingly rare on this continent, or in England, that a lengthy description would scarcely appear necessary. The writer is confident, however, that we occasionally meet with a popular condition attended by intense itching, which is essentially a prurigo, but which does not answer to the description of the disease as given Dr. Duhring.

It is very gratifying to the profession here that so admirable a work as the present should have been published on this continent. It is the most complete text book for students which has yet been published in the English language, and it is doubtful if a better book has ever been brought under the notice of medical men in any language. We would advise all those who wish to possess a thoroughly reliable, and at the same time not unwieldy text book on this important branch, to at once procure this work.

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### Meetings of Medical Societies.

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#### TORONTO MEDICAL SOCIETY.

Meeting of 24th March. Dr. Geo. Wright, Vice-President, in the chair. Drs. James Baldwin and McCullough were elected members. Dr. Workman read a translation from the Spanish of a case of intestinal invagination in which 34 centimetres of gut were passed *per anum*.

Dr. Riddel related a case: A.B., aged 32, robust, syphilitic, hard drinker, came to him with facial erysipelas from which he shortly recovered. Delirium tremens followed with some puffiness of face and extremities. Recovery ensued but in about a month he was seized with convulsions and died. Dr. Graham narrated a case of convulsions developing suddenly

without known cause followed by coma and ending in death with no kidney lesions. Dr. Oldright mentioned a case of empyema in which he tapped the chest and washed cavity out daily by the simple syphon method which he had employed in a number of such cases with gratifying results. Dr. Geo. Wright presented a dried anatomical preparation of ruptured diaphragm.

Dr. Graham reported several interesting cases:

1. For the past five or six years had suffered from frequent attacks of jaundice which finally became permanent. For a year and a half before death occasional heart-murmurs were heard, systolic basic, during the last six months they were permanent. Autopsy showed absence of valvular lesions; the cystic and common bile ducts were obstructed by contraction.

2. A case of lateral spinal sclerosis. *Vide* page 146.

3. Splenic leucocythæmia, white corpuscles in varying proportions at different observations, 1 to 8, 1 to 12, 1 to 15. Red globules averaged 3,000,000 to c.m.

4. Acute tuberculosis—no diagnostic physical signs during life. Lungs found studded with tubercle. Purpura hæmorrhagica immediate cause of death.

5. Age 49. Working in an office he early contracted the habit of retaining his urine all day long. Some catarrhal trouble has now appeared with albuminuria. He thought that there could be no doubt that the kidney-affection resulted from the habitually distended bladder. A general discussion ensued. Dr. Playter then read a paper upon Contagious Diseases in Men and Animals, after which the meeting adjourned.

Meeting of 7th April. The President, Dr. Covernton, in the Chair. Dr. Workman read a translation from the French, describing a case of trephining in an ancient Danish or Norse skull found in a grave of about 200—500 A.D. Dr. Cameron exhibited the lungs from a case of empyema of the left pleura. The patient, a boy eight years of age, was admitted to the Children's Hospital when the disease was of 15 months' standing. Under tonic and anti-

septic treatment he gradually improved and was able to go about, eating and sleeping well. At the end of four months caseous bronchopneumonia manifested itself on the healthy side and in a few days he succumbed. The left pleural cavity contained cheesy and liquid pus; the lung was completely carnified and crowded against the vertebræ which were diseased at points of juncture of second and third ribs. The right pleural cavity contained some clear serum with numerous fresh adhesions. The lung was congested and presented a number of caseous foci. Dr. Oldright exhibited three specimens from the same subject, a man of 73 years of age. (1) The left hip. Thirteen years ago it was injured by a fall downstairs. There were evidences of fractures of the ischium and pubis; the femur fractured through the neck, the head had disappeared and the remainder of neck articulated with the filled up acetabulum and could be dislocated on to dorsum. A rounded piece of bone closely resembling the head of femur was firmly attached, by its edge, just below the iliac crest, behind the superior spine. Another small bony outgrowth existed below and in front of this. The bladder (shown), thickened from chronic inflammation, presented a sacculum at its upper part, and a papillary growth at the neck obstructing the outlet. The left kidney contained a large cyst on the surface extending to the pelvis. The ureters were dilated. Dysentery was the cause of death. Dr. Oldright then read a paper on Contagion and Infection. He confined his remarks principally to some questions of school quarantine, viz.:—The length of time it is necessary to keep scarlet fever cases at home, and the other members of an infected family; and as to the non-necessity of preventing the school attendance of apparently healthy children, where a case of typhoid fever or diphtheria was present in the house. A general discussion followed.

Dr. Workman then moved the addition to the by-laws of which he had given notice, limiting the number of Honorary Members of the Society to twelve. On a division the motion was carried, and the Society adjourned.

## HURON MEDICAL ASSOCIATION.

The regular quarterly meeting of the Huron Medical Association, was held in Clinton on April 5th, Dr. Sloan, of Blyth, President, in the chair.

The following members were present: Drs. Sloan, Holmes, Worthington, Williams, Taylor, Campbell, Graham, Young, and Stewart.

Dr. Worthington showed a young lady with lateral curvature of the spine, who is wearing a "Wyeth's Plaster Jacket" with great comfort.

Dr. Stewart showed a case of badly united fracture of the tibia and fibula.

Dr. Campbell showed a uterine polypus which he removed a few days previously from an unmarried woman, aged 35. For a period of two years this patient suffered severely, before the appearance of the catamenia, from severe pain referred to the region of the uterus. The menses were very profuse, and for some days the loss was so great that she was unable to leave her bed. Dr. C., on making a vaginal examination, discovered a tumour about the size of a hen's egg in the vagina, and having a pedicle which could be traced to the internal os. Dr. Campbell, with Dr. Scott's assistance, removed the polypus by means of a long curved forceps. The patient is doing well.

Dr. Graham, of Brussels, exhibited a beautiful specimen of dilatation of the stomach arising from the cicatrization of a chronic ulcer. The patient from whom the specimen was taken was a blacksmith, 28 years of age. He had suffered for seven years from pain after eating, and vomiting.

About two years ago the stomach was found to be greatly dilated. He had several epileptiform convulsions, and was frequently troubled with severe tonic spasms of the muscles of the lower extremities. Emaciation was extreme. He complained of having a ravenous appetite and uncontrollable thirst. He vomited large quantities of fluid, containing products of fermentation.

Dr. Graham began, at this period, to wash out the stomach. This treatment was continued for five weeks, and was attended by marked benefit. The thirst and vomiting disappeared, and the convulsions and spasms ceased to return. He rapidly gained flesh and strength, and his state was so satisfactory that it was not considered necessary to use the stomach pump any longer. He continued, to



all appearances, in good health until about two months ago, when the thirst and vomiting set in again.

The tonic spasms of the lower extremities returned and were soon followed by death.

The stomach weighed 23 oz.; length from the cardiac to the pyloric extremity, 20 inches; vertical diameter,  $7\frac{1}{2}$  inches. The pyloric orifice has a diameter of only  $\frac{1}{8}$ th of an inch. An ulcer  $\frac{1}{4}$  of an inch in diameter, and nearly the same in depth, with undermined edges, was situated at the commencement of the pyloric orifice.

Dr. Graham concluded the report of this case by saying, \* \* \* The treatment of this case convinces me of the very great benefit derivable from Kussmaul's method of washing out the stomach when this organ is dilated. I feel satisfied that although the pyloric constriction could never be removed, that with proper attention to quantity and quality of food, and the use of the syphon or pump, at the proper time, he may have been tided over many months—perhaps many years.

Dr. McDonald, of Wingham, read the notes of a case where he stretched the sciatic nerve for obstinate sciatica. The result in this case has been very encouraging.

Dr. Stewart gave a report of a case where he and Dr. Hurlburt performed a similar operation for an inveterate sciatica. Sufficient time has not yet elapsed to decide as to the permanent value of the operation in this case.

### Miscellaneous.

#### MEDICAL COUNCIL EXAMINATIONS.

There were 150 candidates for the Professional Examinations, of whom 83 were for final; and 125 for matriculation. The final were written and the primary entirely oral, the anatomy being on the dissected subject. This is the proper method, and it is a mode that is very popular among students who *know their anatomy*.

The following are the final questions:

##### THEORY AND PRACTICE OF MEDICINE.

N.B.—The candidate will only answer the first three questions, and any three of the remainder.

No. 1.—You have been in daily attendance

upon a patient, who has been several days ill; you determine that it is a case of typhoid fever, although no rash is present. Show why it may not be a case of acute tuberculosis or tubercular peritonitis.

No. 2.—(a) Locate the normal superficial cardiac dullness. (b) Record the symptoms and physical signs of dilatation of the right ventricle of the heart, and determine the causative differences between dilatation of the right and left ventricles. Treatment of both.

No. 3.—Distinguish the causes, other than surgical, upon which an unconscious condition may depend; and give a short account of any case which may have come under your own observation.

No. 4.—(a) What are the relative lengths of inspiration and expiration in tracheal, bronchial, and vesicular respiration? Compare the interval in each. (b) In the healthy state of the respiratory organ, where would you expect to find bronchophony? (c) What condition of the lung would it indicate, if found in other parts? and what diseases does this condition of lung include?

No. 5.—Diagnose, describe the characters of, and treat a case of tinea-tonsurans.

No. 6.—Give the clinical history and treatment of acute dysentery.

No. 7.—(a) Illustrate how the thermometer may very materially aid in diagnosis. (b) What are the ranges of temperature in health? (c) In what diseases does hyperpyrexia most frequently occur?

No. 8.—Determine the clinical differences *between*, and give briefly the diagnostic points in chronic gastritis, gastric ulcer, and cancer of the stomach.

F. R. ECCLES, *Examiner*.

##### SURGERY (OTHER THAN OPERATIVE).

No. 1.—Describe the symptoms of—dangers to the eye from—and treatment of a case of simple iritis.

No. 2.—Diagnose intra from extra-capsular fractures of the femur.

No. 3.—Give the symptoms and diagnosis of hip-joint disease.

No. 4.—What is considered the most favourable time for operating after gunshot wounds—and what are the general results of secondary amputations?

No. 5.—What causes may give rise to abscess of the groin, and how would you diagnose from psoas abscess presenting there?

No. 6.—Describe the various forms of cutaneous ulcers, and give treatment of indolent ulcers.

No. 7.—Diagnose a dislocation from a fracture.

No. 8.—When dislocation and fracture co-exist, what is the rule for reduction?

W. P. BUCKLEY, *Examiner*.

#### OPERATIVE SURGERY.

No. 1.—Describe Chopart's operation.

No. 2.—In what case is excision of the elbow joint advisable—and how is it performed?

No. 3.—Describe the operation for vesico-vaginal fistula.

No. 4.—In what part of its course is the brachial artery usually tied, and how is the operation performed?

No. 5.—What are the various circumstances requiring trephining, and how is it performed?

W. P. BUCKLEY, *Examiner*.

#### SURGICAL ANATOMY.

No. 1.—Name the parts divided in tracheotomy. What structures are to be avoided?

No. 2.—In what direction, and to what is due any displacement occurring in fracture of upper third of the thigh.

No. 3.—Name in some order the structures divided in excision of the ankle joint.

No. 4.—What parts are successively divided in the operation of colotomy?

No. 5.—Trace the course of any vessels between the bones of the head and brain, which being wounded may compress the brain.

No. 6.—Give the exact position of the eustachian tube—how would you pass a tube into it?

No. 7.—Beginning at the skin, name each tissue successively divided in removal of the lachrymal gland, and describe the course of the canals whereby the tears are conveyed from the eyeball.

No. 8.—What parts would require division to ligate the popliteal and posterior tibial arteries? State the anatomical difficulties in each case.

M. SULLIVAN, *Examiner*.

#### MIDWIFERY (OTHER THAN OPERATIVE).

No. 1.—Describe the formation of the placenta and umbilical cord from their origin to complete development, and state their functions.

No. 2.—Describe the conditions which will retard the progress of labour in the first stage, and specify those cases in which, if left to nature, the result to the mother would be serious, perhaps fatal; give treatment.

No. 3.—What is placenta prævia? Give symptoms, diagnosis, prognosis, and treatment.

No. 4.—What is menorrhagia? Give its causes, symptoms, and treatment.

No. 5.—Give the symptoms, pathology, prognosis, and treatment of phlegmasia dolens.

H. ROBERTSON, *Examiner*.

#### MIDWIFERY (OPERATIVE).

No. 1.—What are the objects of craniotomy? In what cases is it justifiable? Describe the method of operating.

No. 2.—In what cases is cesarean section justifiable? State the object of the operation, and describe it fully.

No. 3.—What is ovariectomy? In what cases would you recommend it? Give the operation and treatment.

No. 4.—State the causes of vesico-vaginal fistula; give symptoms and treatment.

No. 5.—How is inversion of the uterus produced? Give symptoms and treatment.

H. ROBERTSON, *Examiner*.

#### MEDICAL JURISPRUDENCE.

No. 1.—Distinguish between ante-mortem and post-mortem twins.

No. 2.—What is the average term of gestation—the shortest term compatible with full development of fœtus—and the longest term?

No. 3.—In a case of infanticide from strangulation, what signs, if any, would show that strangulation took place after an independent circulation had been established in the body?

No. 4.—To what extent is generative power developed in cryptorchids?

No. 5.—What symptoms would give rise to a suspicion of poisoning? and in such a case, what points in its history, in the appearance of the body, and in the surroundings, should be noted?

No. 6.—Do you consider the following case one of suicide or homicide? Give reasons for your opinion:—A man found dead—lying on his face—with throat cut, right arm placed under body, with right hand near left shoulder; and close to right hand a razor found open with blade smeared with blood; blood on neck and chest; incision in throat four inches long and two and one-half deep, extending obliquely from about an inch above left collar bone to right side of chin, dividing all the vessels and anterior vertebral muscles—deepest part of incision at right angle of wound, and extending behind the unbroken skin.

W. T. CAMPBELL, *Examiner*.



# THE Canadian Journal of Medical Science.

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## Original Communications.

### OLD TREATMENTS REVIVED.

BY R. L. MACDONNELL, B.A., M.D., M.R.C.S.

Assistant Demonstrator of Anatomy, McGill University.  
(Read before the McGill Medical Society.)\*

Mr. President and Gentlemen,—It is, I believe, the fashion for the student and practitioner of the present day to suppose that all the treatment we have in use to-day is modern, dates with the century, and that our grandfathers and great-grandfathers knew little or nothing, their treatment was ridiculous, and their diagnosis and prognosis uncertain. As for diagnosis, without a uterine speculum (really an ancient instrument), no sound, no thermometer but the naked hand, no rhinoscope, no laryngoscope, no stethoscope, in fact with nothing whatever in the shape of a 'scope or an 'ometer, how could they make head or tail of disease when they came across it? There was one faculty cultivated in those days which to-day is very much neglected, that of the observation of the sick. The temperament, the physiognomy, the decubitus are left now entirely out of the clinical record, while the paper is filled with notes of temperature, of amount of urea, &c. This difference between now and then struck me forcibly when comparing a number of clinical reports in my possession, made by some of the senior members of this faculty at a time when they were students. Take as an example the physiognomy in pneumonia: Do we

take as great care now to note the malar prominences, the herpes, and the other outward and visible signs of this disease which in some cases is so easy, in others so hard of diagnosis?

One cannot help wondering while reading the aphorisms of Hippocrates how such a collection of truths, truths verified by the experience of centuries, could be arrived at, at a time when the observers had none of our modern instruments to guide them; not even a knowledge of anatomy, or an inkling of the key-stone of physiology—the circulation of the blood. We are too fond of thinking that nothing was known of the diseases of the lungs until the invention of auscultation; yet a careful study of these aphorisms will enable a practitioner to make a good prognosis. I wish to deal, however, this evening with various plans of treatment, some of which I was myself mistaken in supposing them to be of recent origin.

Apart from general considerations, is there not much so-called modern practice of very ancient origin, and are there not in many new practices, old ones dressed up in modern garb? Let us begin with the plan of puncturing the testicle in acute orchitis. Many are under the impression, that the procedure which is, by-the-by, one of very doubtful utility and not free from danger, was originally brought before the notice of the profession by Mr. Henry Smith, of St. Bartholomew's Hospital, but the revival of this plan is the work of M. Vidal de Cassis, Surgeon to the Venereal Hospital in Paris. In the American translation of his treatises "On Venereal Diseases," (1854) he strongly urges puncture of the testicle in cases where the pain is very intense. "I puncture the tunica albuginea with a lancet or sharp-pointed bistoury,

\* The McGill Medical Society is composed of students. Meetings are held fortnightly during the winter, and weekly during the summer session, for the reading of papers and the exhibition of pathological specimens.

the opening being little more than half-an-inch in extent. This operation is attended with no more pain than that of puncturing the tunica vaginalis. Its safety is established beyond a doubt. I have operated upon more than 400 patients in private practice and at the *Hôpital du Midi*." M. Vidal thought that subsequent atrophy was almost an impossibility after this operation. The operation is, however, much older than M. Vidal, or any surgeon of this century.

Another method of treatment one might say unknown, at all events, neglected, except by a few, is acupuncture. That in lumbago, pain is relieved by this proceeding is almost beyond a doubt. Is it not by this process for which, to be sure, we have no scientific *rationale*, that pain in orchitis is relieved, and in those cases where relief has been given by hypodermic injections of water, did not the puncture effect a part of the relief given?

"I have treated a large number of such cases (lumbago) by acupuncture and find that it gives almost instantaneous relief." This is Dr. Ringer's statement.

Acupuncture is a remedial agent which had its day, experienced ups and downs, and seems to-day likely to recover its old place in the estimation of the profession. Its history may perhaps interest you. We are told by Dr. Elliotson, in his essay on this subject, in the *Encyclopædia of Practical Medicine*, that it is of very ancient origin; that the Chinese resorted to it from time immemorial, its use being founded on the principles of the old humoral pathology. The puncture, they thought, allowed the vapours to escape.

Zen Ryne, an officer of the East India Company, first brought to Europe an account of this treatment; publishing, in 1693, his "*Dissertatio de Arthritide, de Acupuncturæ*," &c. He, as well as Kœmpfer, a medical attaché to the Dutch Ambassador to Japan in 1691, reports that a needle is introduced into the belly in cases of colic, and allied conditions. The orientals did not limit this operation to the treatment of affections of the belly only. It is specially mentioned in connection with the treatment of swelled testicle. Thus, you see that the puncture of that organ in orchitis is

not of such recent date as many suppose. Dr. Elliotson states, that owing to the alarm excited by running needles into the flesh, and the high improbability of any benefit from such a practice, a hundred and seventeen years elapsed before any European practitioner made trial of it. It was mentioned in the writings of Dryardin and Vicq d'Azyr, some 100 years afterwards, but mentioned in order that the world might be congratulated that the statements of Zen Ryne and Kœmpfer had not induced any one to practise it; and it first attracted attention in 1810, from the strong support of M. Bertioz, of Paris. Numerous French practitioners imitated his example, with the same results. The English soon took it up, and acupuncture affords a striking instance of a good remedy discovered from groundless hypothesis, and condemned without a trial for above a century.

The treatment of gout, one would suppose, would improve from century to century. With, perhaps, the omitting of venesection, the gouty grandee of 1881 is treated scarcely better than he was a thousand years ago. Colchicum, which, as every one knows, is the alpha and the omega of gout, the "*anima articulorum*" soul of the joints, was recommended and used by Alexander of Walles, a city of Lydia, in the sixth century, for cases of gout, not under the name of colchicum, indeed, but of hermodactyls, which are said, by Sir H. Halford, to be one and the same thing. Alexander's prescription consisted of hermodactyls, ginger, pepper, cummin seed, aniseed, and scammony; which, says he, will enable those who take it to walk immediately.

Bullock's blood, which is used largely in the United States, as well as elsewhere, for a remedy, in consumption, was at one time thought to be poisonous, and it is reported by Plutarch that Hannibal put an end to himself by drinking it. Its use as a remedy in phthisis appears to have its origin with the Spaniards, for the earliest mention I can find of it is in some of Sir Henry Halford's lectures, published in the early part of this century: "An accomplished nobleman told me that he was present at one of the bull-fights at Madrid, when a person rushed into the crowd, and having made his



way to the bull, which the matador had just stricken, caught the blood as it flowed from the wound, in a goblet, and drank it off before the assembly. On inquiring into the object the poor Spaniard had in view, it appeared that the blood of a bull just *slain* was a popular remedy for consumptive symptoms."

Returning to surgery, the use of the self-absorbing ligature, is one of the things looked upon as part of the all-appropriating Listerian system, but it is older than that. Sir Astley Cooper used for a short period ligatures of catgut and deer tendons. The early American surgeons used ligatures of chamois skin, kid, buckskin, the tendons of deer, catgut, and strips of parchment. Chelius makes this statement: "The practice of removing both ends close to the knot, published by Haire of England, in 1786, was adopted by Hennen in 1813, at the suggestion of one of his associates, who believed it to have been an American invention."

The drainage tube, too, was used in the last illness of Philip II., of Spain, as has been shown recently by a writer in the *British Medical Journal*.—(March 5th, '80).

In a work now before me, entitled the "*Mellificium Chirurgiæ*," or, "The Marrow of Surgery," an anatomical treatise by James Cooke, of Warwick, published in 1685, there are many things which remind one of the practice of the present day, though I must confess the bulk of the treatment is rubbish; for instance, he recommends the tying of a live mouse to the thigh to cure prolapsus uteri; and advises the moss of a dead man's skull in epilepsy. However, amongst his weapons, as he calls them, we find sponge tents and dried roots to "dilate fistulas, to keep up the womb, and keep open issues." He also mentions his speculum ani and matricis, "where diseases are which, unless discerned, cannot well be cured." Again, amongst the accidents after child-birth, is described "milk abscess," and its preventative treatment. "Juice of deadly nightshade, or rather the fresh leaves laid on the paps, mollifies, discusses, and heals the hardened tumours, yea, cancers, oft tried." Perhaps his last statement requires modification, but as to such a course being decidedly palliative no one can have a doubt.

Mr. Coke's description of opium is so very quaint, that though it has very little bearing upon the subject, I cannot refrain from quoting it, "*Laudanum Opiatum*. 'Tis a gallant anodyne, seldom frustrates expectation, but helps without trouble to the brain, against pains from whatever cause arising, all hemorrhoids, and fluxes of blood, in what part of the body soever; against all defluxions: therefore gr. i. is excellent in the chin-cough; procures rest in the fevers, bridles the raging of the humors, is excellent in madness, melancholy, vomiting, epilepsie, hiccough, colick, weakness of the stomach, pleurisie, all sorts of gout and stone."

Suppositories for the urethra are regarded as modern, at least I have always done so, but old Cooke, of Warwick, writes as if they were old in his day. In the treatment of gout depending upon a granular condition of the urethra he strongly recommends their use. "To this may be referred candles of wax, anointed with fit medicines, and put into the yard to cure caruncles." He then refers the reader to Sculletus and other writers.

In the London *Lancet* (May 12th, 1866) there is an article headed "A Novel Treatment of Gonorrhœa and Gleet," in which it is said, "we have been interested lately in observing a new process (viz., the treatment by bougies) which is now being tried by Mr. Henry Thompson, at University College Hospital." Scarcely had this article been published when two surgeons wrote to the *Lancet*, claiming the honour of the invention. Then Sir Henry writes a letter stating that its origin is of ancient date prior to the time of Wiseman.

Another old book in my possession, is written by Gideon Harvey, M.D., "their Majesties Physician of the Tower, and Fellow of the College of Physicians of the Hague." This book was printed in 1689. Now, this writer, a heretic in a medical way, devotes in a very quaint fashion his talents to denouncing the polypharmacy prevalent in his time, for in those days even our friend Cooke's prescriptions contained no end of trash, and asserting as we do to-day that nature cures the disease with or without the physician's aid, often in spite of the physician. In fact his views coincide with the

spirit of that old and trenchant satire which described nature and disease as the two opponents fighting over the sick man, and the physician as a blind man who advanced with a club to settle the contest between them, and dealt heavy blows which might sometimes fell the one and sometimes the other as chance directed.

The book is called the "Art of Curing Diseases by Expectation." Expectation he defines in these words: "The applying of remedies, that do little hurt, and less good, from which the patient day by day frustraneously expecting relief and benefit, is at last deferred so long, that Nature and Time have partially or entirely cured the disease, which notwithstanding the physician by subtlety, cunning, and officiousness, doth commonly with success insinuate, that the patient is debtor for his life and recovery to the doctor's skill, judgment, method, and remedies; and in this particular the wisest of men do become half fools by intrusting their lives, and yielding obedience to most physicians, of whom, or their art, they are incapable of judging by reason of their being unacquainted with the inside of their persons, and the vanities of their profession."

In fact were I to continue I could show that he treated disease very much on the same plan as we do to-day; but to mention what he says of each disease would only make longer an already too long paper. I cannot, however, put the book into its place without telling you what he says of his great namesake and contemporary—the discoverer of the circulation of the blood. After stating that anatomists were invariably poor physicians, "an instance whereof I will give you in one, that was the greatest anatomist of his own time, and no extraordinary physician, namely, Dr. William Harvey, whose erroneous judgment was very remarkable in the prescription of a purge for Esq. Rainton, of Enfield, where the apothecary refraining to prepare more than half the proportion, notwithstanding gave him four score stools, which otherwise, according to the doctor's measures, must unavoidably have scowered him from the close stool into the other world." Later on, speaking of consultation, he says, "the fore-mentioned Dr. Harvey ingrossed

to himself the speaking part by reason of his extraordinary claim to anatomy, and which here, if anywhere, seemed to be of use; after a long contrectation of all the abdomen, did very magisterially and positively assert all his symptoms to arise from an aneurism of an artery, and therefore incurable, as being too remote to come at, wherein all except Dr. Bates very readily concurred, though it was a most absurd offer in opinion; as ever I yet heard." The case turned out to be one of enlarged mesenteric glands. If I may be allowed again to digress, I may say that Gideon's statement as to Harvey's talents as a practitioner are not unsupported by contemporary evidence.

John Aubrey, who was at Harvey's funeral and "helped to carry him into the vault," writes: "I have heard him say, that after his book of the Circulation of the Blood came out he fell mightily in practice, and it was believed by the vulgar that he was crack-brained; and all the physicians were against his opinion and enjoyed him. All his profession would allow him to be an excellent anatomist, but I never heard of any that admired his therapeutique way. I knew practitioners in this town, that would not have given him 3d. for one of his bills (prescriptions), and that a man could hardly tell by one of his bills what he did aimed at."

But here I am wandering from the text of my paper in disquisitions as to Harvey's capabilities as a family doctor.

Dr. Paris, in his "Pharmacologia" tell us that the history of the warm bath presents us with another curious instance of the vicissitudes of therapeutic agents. That which for so many ages was a luxury in health and an efficacious remedy in disease fell into total disrepute in the reign of Augustus, because Antonius Musa had cured the Emperor of a dangerous malady by the use of the cold bath. Cold bathing became fashionable. This practice enjoyed ephemeral popularity, for although it had restored the Emperor to health it shortly afterwards killed his nephew and son-in-law, Marcellus; an event which at once deprived the remedy of its credit and the physician of his popularity.



James' powder was an Italian nostrum, invented by a person named Lisle, a receipt for the preparation of which is to be found at length in Colborne's Complete English Dispensatory for the year 1756. Battley's sedative solution of opium is also said to have been of ancient origin, the prescription having come from Windelius, Lemort, or some other writer of the olden time.

No one would accuse Mr. Hilton of using other men's ideas; for his work on "Rest and Pain," I regard as Trousseau regarded "Graves Clinical Lectures." I would have it read and re-read as a priest reads his breviary; yet the principle upon which his plan of opening deep-seated abscess is based is an old one. Lisfranc, in 1829, in clinical lectures published in the *London Medical Gazette*, describes something very like this method. He cuts down to the deep fascia with his knife, then forces his director or probe to the supposed site of the pus, dilating the hole formed with another probe, instead of the dressing forceps recommended by Hilton.

On our library table downstairs you will see a pamphlet in which sanitary maxims are instilled into the minds of the populace by aid of rhyme. Such tracts are distributed about England and elsewhere on the same principle that an ingenious individual uses who attempts to imprint upon the plastic mind of the student the grand solemn truths of *materia medica* by rhyme such as—

"Six ingredients, you must know,  
Compose the Tinct. Chinchonæ Co."

Again, we find such sanitary rhymes of very ancient date. I have before me as I write one of our Faculty Library's books, entitled "Regimen Sanitatis Salerni, containing most learned and judicious directions and instructions for the guide and government of man's life. Dedicated unto the high and mighty King of England, from that University, and published for a general good. \* \* \* \* \* Printed by B. Alsop and T. Fawcet, dwelling in Grub-Street, neere the Lower Pumpe, 1634." The opening advice, in fact the preface, is as follows:

Anglorum regi scripsit Schola tota Salerni,  
Si vis incolumen, Si vis te reddere sanum :

Curas tolle graves, irasci crede prophanum.  
Parce mero, cenate parvum, non sit tibi vanum.  
Surgere post epulas, somnum fuge meridianum,  
Non mictum resine, non comprime fortiter anum  
Hæc bene si serves tu longo tempore vives.

All Salerni schoole thus write to England's King,  
And for man's health, these fit advises bring.  
Shun busy cares, rash angers, which displease;  
Light supping, little drinke, doe cause great ease.  
Rise after meate, sleep not after noone,  
Urine and Nature's need, expell them soone.  
Long shalt thou live, if all these well be done.

Unfortunately the sanitary rhymes of 1634 would cause great scandal amongst the sanitary people of 1881, for listen to what is said about water drinking:

"He that drinks water when he feeds on meat,  
Doth divers harms unto himself beget,  
It cooles the stomache with a crude infesting  
And voydes the meat againe without digesting."

In those days, I believe, when paterfamilias fell ill after a public dinner, he ascribed his nausea, his headache, his unsavoury mouth, not to the salmon as they do now, but to the nuts, else why this caution:

"A new layd egge, craves a good cup of wine  
Drunk after it, it will the blood refine.  
Nuts after fish, cheese after flesh is best,  
In both these they are helpful to digest.  
One nut doth well, the second doth offend—  
Beware the third, it brings a deadly end."

I have now come to the end of a long, and it must be said, very rambling paper. I hope that I have shown you that there is some truth in the old saying that "There is nothing new under the sun," and also that I may have encouraged you to devote some of your leisure time to the old literature of our profession by which you will not only gain some instruction, but considerable amusement.

#### PERIPHERAL PARAPLEGIA.

BY JOHN FERGUSON, B.A., M.B., L.R.C.P., EDIN.

There are a certain number of cases of paraplegia, which run a peculiar course, have many symptoms that are rather difficult to interpret, and, after a varying period of illness, eventuate in recovery, more or less complete in the major-

ity of cases. Many members of the profession must have met with cases, the true nature of which it was very hard to ascertain; and which, in their causes, clinical history, tendency to recovery, and involvement of the hands or feet, while the more proximate portions of the extremities escaped, or did so for a time at least, did not coincide with what one would expect were the signs and symptoms due to any definite lesion of the cord or brain. There has always been a somewhat vague idea running through the pathology of such cases, and but little has been done, that is at all satisfactory, in the way of treatment. The following is an epitome of the clinical history of the cases I am now considering: The person begins to feel a strange tingling in the feet and hands, or it may be at first only in one or other of these parts. This feeling of tingling, with a sort of numbness and loss of sensation, gradually extends up the members towards the body. For this condition the patient may be able to assign no real cause, further than the indefinite and unsatisfactory one of exposure on some previous date, to cold or wet. The sensation of the parts are first affected, and after the lapse of some days, or even weeks, the motor functions become impaired. The advance of the disease is constant, though not marked by any definite rate of progress. As this advance takes place, the entire lower or upper extremities become involved, or both may suffer, though not to the same degree. The patellar tendon reflex action is retained, and there is often well-marked hyperæsthesia, which may be more or less general or circumscribed to a small area. As the disease progresses, and the sensory and motorial functions become more and more implicated, there is a gradual loss over the organic functions.

The bladder now suffers and the patient can no longer void his urine, or can do so only with great effort. The bowels become deranged, and obstinate constipation is a source of much trouble and discomfort. The girdle pain, often complained of by paraplegics, frequently comes on about this stage, and causes intense suffering, while others are more favored, and complain only of great uneasiness from this symptom. The respiratory functions generally escape, or

are but slightly interfered with; while the intellect remains intact.

With these remarks on the character of the affection, let us now try to ascertain the seat of the lesion. This point has been much debated, especially among the German authorities. Three places suggest themselves, namely, the brain, the cord, or the peripheral endings of the nerves. We will now take these up in turn.

With regard to the brain as the seat of the lesion it may be remarked, that paralysis from such a cause would be unilateral, except in three general cases: paralysis of the insane, when the lesion affects some portions where the nerves decussate, and when there is simultaneously either disease or injury on the opposite sides, there would be bilateral paralysis. Now, the cases we are considering are bilateral; but while this is true, it is equally clear they can not come under the three general cases just stated. The clinical history excludes all chance of their being confounded with general cerebral paralysis of the insane. On the other hand, if due to disease or injury so seated as to render the paralysis bilateral, the progress of the disease would be very different from that recorded as "peripheral paraplegia." We may, I think, safely set aside the brain or medulla as having anything to do with our present subject.

This brings us to the second part, whether the lesion is situated in the cord or not. Here the case is not so easily dismissed. In favor of the cord being the seat of trouble we note: (1) that the paralysis is bilateral as might occur from the cord; (2), that it is paraplegic; (3), that there is the girdle pain; (4), that there is the loss of motor and sensory functions, and (5), that the organic functions become impaired. Against the view that it is due to lesion in the cord, we have: (1), that the distal parts of the extremities first suffer; (2), that the paralysis then extends towards the body; (3), that sensation appears to be first affected and motion secondarily, but that sooner or later both are involved; (4), that the girdle pain comes on at an advanced stage of the disease, and (5), that the organic functions, as the movements of the bladder and intestines, also belong to an advanced period.

Leaving this for the present, let us ask if



such cases of paralysis could depend upon a peripheral origin? In favor of this view, we notice that the first appearance of the disease is in the hands and feet, and that all the other symptoms come on just as it progresses upward along the nerve trunks; and finally when the cord becomes affected, we have the conditions of a paralysis due to central mischief. These cases were suspected to depend on some abnormal state of the nerve endings, although there were no pathological proofs of such. Within a short period, Prof. Leyden, who has devoted much time to the subject, has made a number of post mortems, and collected the records of others. It is not often that an opportunity is granted of making a post mortem, as the cases are not generally fatal. There are, however, examples where the patient was killed accidentally, or perished of some other disease, and thus offered means of verifying conjecture by actual observation. The results of these observations go to show that there is a diffused neuritis of the peripheral ends, and that this inflamed condition spreads along the larger trunks and reaches the cord. Under this view anomalies of these cases of paraplegia become easy of interpretation, and a more rational treatment is likely to be adopted.

Nothing very definite is yet known as regards treatment. So far, a judicious system of shampooing, tonics and the long and continued use of ergot, have met with the best results.

### NOTES ON THE NEW YORK HOSPITALS.

(By J. E. Graham, M.D., L.R.C.P., London, Lecturer on Dermatology and Clinical Medicine, Toronto School of Medicine.)

One might be accused of presumption in writing an article on such a subject as the New York Hospitals, as they have, no doubt, been visited by a very large number of the readers of this Journal. Impressions have been made, however, on the mind of the writer, during a recent visit which he has the hardihood to publish, and which the profession can take for what they are worth. The remarks about to be made, may, perhaps, be of some use in the management of our own hospital. There are many features of the New York Hospital system

which we would do well to copy, while there are many other characteristics which we would do equally well to avoid.

So far as the nursing, and general treatment of patients go, nothing better can be desired. In fact, in passing through the New York Hospital one is inclined to think that it is too luxuriously fitted up. It is doubtful if it is good policy to have a simply charitable institution fitted up almost like a mansion or palace. There are probably many treated there who could well afford to remain at home and pay their medical attendant for his services.

One is struck with the great number of very excellent courses of instruction which are given in the various Hospitals and Schools. The almost universal ability shown by the various lecturers, places them, in my opinion, equal, if not superior to any similar class of men in the world. The question has often arisen in my mind, why do not students come from Europe to America to finish their education in as large numbers as they go from America to Europe? When one thinks of the almost inexhaustible amount of clinical material, and of the excellent standing of the lecturers, one would be puzzled to answer the question. The reason generally assigned is that there are no such highly endowed institutions on this Continent as in the Old World, and that lecturers have to spend too much time in simply making a living, and consequently, cannot devote themselves to teaching so much as they otherwise would. There is, no doubt, some truth in this argument, but it does not furnish the real reason for the comparatively speaking incomplete education which is received by medical students here. The fault lies in the whole system as it is now conducted, and if radical changes are not made education will still remain defective, and students will continue to flock to Europe for advantages which they could just as well enjoy on this side of the Atlantic, if some changes were made in the school management.

As it is at present there are only three classes of students, whose education can be said in any sense to be complete. (1) Those who after graduating, spend two or three years in Europe in large hospitals. (2) Those who have been fortunate enough to receive hospital appoint-

ments, as resident physicians and surgeons, and (3) those who have had exceptionally good advantages in the office of their preceptors. The students in these three classes would not amount to more than a fourth of the whole number, leaving at least three-fourths who go into practice incompletely prepared, many of them, of course, afterwards make up to some extent their deficiencies. Many on the other hand do not. It is this system which accounts for such extremes in the acquirements of medical men throughout the United States.

The opportunities for clinical study in New York are not excelled by those of any city in the world, but they are not sufficiently thrown open to students, so that all could to a greater or less extent reap the advantage of them. Clinical lectures and private classes are all very well in their way, but they are no substitute for the bed-side experience, which can be acquired by the clinical clerks in the London Hospitals. A stranger, not perhaps knowing the difficulties in the way, is surprised that no attempt has been made to establish a hospital school similar to those in London. A school which should have its hospital, so far as the medical department is concerned, entirely under the control of the Faculty. If such an institution were established, very many of the defects at present existing would be removed. The term of service for the resident physicians might be shortened and a thorough system of clinical clerkships established. The number of students attending a school of this character would, no doubt, be very large, and we might soon expect to see many coming to this continent from the other side of the Atlantic, to secure the advantage of instruction from the very able men who now adorn the profession in New York.

Here in Toronto we are copying on a small scale some of the more prominent faults of the New York system, and adding many others which it does not possess. We have two schools where we should have but one. There is very little unanimity in hospital work, such as is necessary to carry on clinical teaching successfully. We do not encourage, to any great extent, practical work on the part of the students, when we should not only encourage

but enforce it. No proper records of cases are made in the hospital. When the present very active Pathologist makes a *post mortem*, and records the notes of it, no record is to be found of the history of the case. Students pay the Faculties of schools for clinical lectures, which for want of time, are never properly given. The mere admitting of patients which is done each day, is not, and cannot be considered in any way as a clinic.

Is there no way by which these grievances can be removed? Will nothing wake the senior men of the Faculties, and many of the junior also, to the fact that in this progressive age only those schools will finally succeed in which the clinical teaching is carried on thoroughly and systematically? It matters not what appliances a medical school possesses for purposes of teaching, it will prove a decided failure, if the greatest attention is not paid to bed-side instruction. At the recent clinical examination of the Toronto University, the Vice-Chancellor, although a layman, could see the defects in the students when they were asked to make a diagnosis of a case. How can students be expected to show any familiarity with work they have never been called upon to do. There is no doubt but that there has been a good deal of improvement shown during the last two or three years in the clinical teaching given in the Hospital, but vastly more must still be accomplished if we wish to keep pace with the times.

FOR A DINNER-PILL.—J. Milner Fothergill, M.D., writes, in the London *Practitioner* for January:—Ipecacuanha formed a portion of a good old-fashioned dinner-pill; and betwixt its direct action upon the gastric mucous membrane and its action on the liver as an hepatic stimulant, it must come into use again before long. A dinner-pill of—

R	Pulv. ipecacuan.....	gr. j
	Strychnæ.....	gr. 1-20
	Ol. pip. nig. ....	m ij
	Pil. al. et myrrh. .	gr. ijss,

every day, will often produce excellent effects. Then arsenic may be taken, as three drops of Fowler's solution after dinner, or in the above pill, substituting the same dose of arsenic for the strychnine.



## Selections: Medicine.

### A MEDICAL IDYL—THE IDEAL AND THE PRACTICAL.

Some years ago a young man named Eidolos graduated at one of our best medical colleges. He had formed his ideal of the true physician and intended to regulate his life by the standard which he had set himself, and resolved to so control and govern his every action that in the end he would attain unto the likeness of that exalted type the image of which was enshrined within his breast. The last words of the eminent man who had addressed his class on the day of graduation were: "preserve your ideals." These words constantly rang in the ears of the young man and he adopted them for his motto.

He located in a small lumbering town in the northern part of Michigan, whose streets were still encumbered with pine stumps. Here he began the practice of his profession and was not long without applicants for treatment.

A lumberman in a neighbouring camp was taken sick and our new man was sent for. The case proved to be one of pneumonia. Lumber camps afford but little in the way of care and nursing—they are not hospitals. Our doctor did all he could and attended him faithfully for two weeks but the patient died. The "boys" took up a collection and bought a \$40 coffin and gave their dead comrade a \$30 funeral, when after paying the apothecary's account there was \$5 left for the doctor. People said he was not practical or he would have secured his whole bill.

Late one night the doctor was visited by a strapping young fellow who lived some distance in the country. He was backward about making known his errand but it came out at length that he wanted some "driving medicine." He had been too intimate with a young woman in his vicinity and he wanted something to "drive" the impediment to the menstrual flow out of the way. Our doctor read him a lecture on the enormity of the proposed practice and urged him to marry the girl. In a few months thereafter the doctor attended the young fellow's wife in confinement. His fee for the

service was in money *nil*, but in satisfaction at the result immense. Here again he was not practical for the young fellow had been prepared to pay for the medicine.

Soon afterwards Dr. Eidolos removed to a larger and more flourishing town.

Among those who first called on him was the wife of a prosperous merchant. She stated that they had one child and did not desire another *so soon* and she thought she was pregnant. An examination revealed the fact that her surmises were correct. The doctor's aid was solicited to avert the trouble, and the request was backed up by the proffer of a \$50 bank note and the covert offer of her favours. The doctor was young, handsome, and poor, and he was more than mortal. He declined; you see he had an ideal. The lady soon after was taken ill and Dr. Praxis attended her. He said she had a severe cold and would soon be well. The result justified his predictions. Praxis understood his business and was soon getting all he could attend to. This lady said Eidolos was not a practical man.

One day Eidolos called to pay a visit of courtesy to a lady patient who was almost convalescent from a tedious illness. With her returning health the fires of passion burned afresh and as he rose to leave she stood against the door barring his exit from the room and inviting him by word and look to her embrace. Dr. Joseph Eidolos was equal to the occasion. He said it was impossible, and then smilingly, gently, firmly he opened the door and departed. This lady was heard to express her opinion that he was not a practical man. Praxis would have been more accommodating.

About this time a lady well on in years, the wife of a prominent official in one of the churches, asked the help of Dr. Eidolos in what she called an "accident." Their children were grown up and they did not desire any more so late in their married life. Eidolos declined to interfere, and she had recourse to Praxis who prevented the accident. During their conversation she referred to Eidolos in this way:

"Do you know Dr. Eidolos?" she asked.

"Yes."

"Do you think he is a practical man?" "No."

"But you are, Dr. Praxis." "You bet."

Praxis had been a drayman, had attended one course of lectures in a reputable institution and then bought a diploma at the factory. He was not troubled with ideals.

There was a fellow on Mount Ararat waiting for the ark to land. His name was Praxis, and he was a commercial traveller. But when he found that Noah and his family were all sick he turned doctor. (He had one of Buchanan's diplomas in his pocket.) That man's descendants have been doctors ever since, and they are a numerous lot. These are they who open medical institutes in the cities, and have stated days for visiting the rural places; who flood the country with circulars and have whole page "ads" in the dailies. Every one is their victim that they can fasten on, and they are your true "leeches."

Praxis also resides among the dwellers in the larger cities of the east, and anon he writes a book the sales of which amount to a single copy. Occasionally he converses with himself on some current topic, and has the interview published in the daily newspapers. His most delightful aspect is when he postures as a hybrid between a scientific acrobat and a medical mountebank to amuse an audience with a performance on "Trance" or "Hypnotism." This is the kind of a subject which gives Praxis a chance to keep himself before the public, where only he thrives, while the pseudo-scientific world gapes with wonder at his lore.

But where is Eidolos. He also is a dweller in the city. Is he an iconoclast? Has he shattered his idol? Has he cursed his god and gone to practising on his "cheek?" Not he. A well-known, quiet, and unobtrusive man, he pursues his daily round of duty. He is ready in counsel, and of high repute in his chosen walk. On occasions he contributes to the journals, and his articles are well-studied and full of meat. Honour, and fame, and wealth, are coming to him. He cannot attain his ideal here for now his motto is "Excelsior."

And where is Praxis? Some of him are in the penitentiary, and the rest keep their old ways.—*Michigan Medical News.*

## CASES ILLUSTRATING THE USE OF ENEMATA OF DEFIBRINATED BLOOD IN PHTHISIS.

CASE I.—Archibald Sinclair, aged twenty years, admitted August 18, 1880. The patient, at the time of his admission, was in the third stage of catarrhal phthisis. There was a cavity at the apex of the left lung. He was exceedingly anæmic, and had been rapidly emaciating. There was very pronounced hectic, with frequent and exhausting night-sweats. He had been losing steadily in weight before commencing the blood-treatment, notwithstanding the usual treatment of cod-liver oil and iron, combined with a most nutritious diet. His weight before commencing the blood-injections was 101 pounds.

November 25th.—Four ounces of defibrinated bullock's blood, to which four grains of chloral hydrate had been added, were administered per rectum at bedtime, in addition to the usual treatment.

December 9th.—The injections of blood have been administered every night since the previous note. After several injections had been given it was found necessary to reduce the amount to two ounces, the rectum not tolerating the original amount. By continuing the smaller amount for a few days, and then adding five drops of tincture of opium to each four ounces of blood, no difficulty was subsequently experienced in retaining the full amount. The weight of the patient, after two weeks' treatment, shows a gain of seven pounds. His entire appearance is changed. He has an excellent appetite, has had but one slight night-sweat, and is decidedly less anæmic. He expresses himself as delighted with his evident improvement. A steady improvement in weight and in his general condition has continued up to the time of this report, one month from the last date.

CASE II.—Maria Durnin, aged twenty-two years, admitted November 13, 1880. The patient gave a very direct phthisical history for eight months past. There was very marked hectic, the evening exacerbations varying between 103° and 104° F. The cough was paroxysmal and violent. She was emaciated, without appetite, and for two months had been



subject to constant vomiting. Her weight before commencing treatment was 101½ pounds. A physical examination revealed a large cavity at the apex of the right lung, with a smaller cavity at the left apex.

November 27th.—Four ounces of defibrinated blood were administered per rectum at bedtime. Seven grains of oxalate of cerium were administered night and morning. The diet was limited to milk and beef-tea. No other treatment was employed.

December 11th.—The injections have been retained without difficulty. The weight of the patient has remained unchanged, but the improvement in her condition is beyond question. Food by the mouth is retained without difficulty for the first time in two months. There is an improvement in the appetite, the heavy coating has disappeared from the tongue, the cough is less frequent and less severe. There is a considerable colour in the lips and cheeks, which were completely bloodless before commencing treatment. The patient is able to sit up the greater part of each day. Several weeks later the improvement continued.—*Medical Review.*

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### ELECTRICITY.

Prof. Bartholow (Med. News and Abstract, Jan. 1881, p. 5), in regard to the use of electricity in disease, makes the following observations. The Faradic current should not be used in ordinary hemiplegia, unless there should be wasting, degeneration and impaired electro-contractility, and also late rigidity. Galvanize the contracted parts and Faradize the relaxed or weak parts.

Paralyzed members receiving their innervation from a diseased part of the spinal cord, lose their electro-contractility to the Faradic current; but preserve it when that part of the cord whence the nerves are given off is healthy, though the cord elsewhere is diseased.

If the motor trunks are diseased, the contractility declines, the muscles degenerate and fail to respond to Faradization, but yet for a time respond to Galvanism; finally they are insensible to that. If the nerve recovers, it is

found that the response to the will takes place sooner than to electrical stimulation.

When paralyzed muscles respond to Galvanism but not Faradization, the former is used until the time comes when the latter elicits response.

The Faradic current is of little service in loss of sensibility.

The property of relieving pain belongs to the Galvanic current.

In internal maladies Galvanism is used because it penetrates to the deep organs, and Faradization does not; the latter tetanizes the blood vessels. Galvanism stimulates the peristaltic action of the intestines.

The tonic and reconstituent effects which follow the application of Galvanism to the cervical sympathetic, pneumogastric and spinal cord, are doubtless due to increased action of the vessels and stimulation of the nervous apparatus which presides over the movements of the chylopoietic viscera. Also in intracranial disorders of circulation, due to weakness of vessels, the current should be weak and only applied for a few minutes.

In applying electrodes, he says that, in Faradization, well-moistened, sponge electrodes are used when it is desired to reach the muscles; for a single muscle, the olive-pointed electrode. To Faradize the skin thoroughly, dry it and dust with powder. To Galvanize; for single muscles and separate nerve trunks, use small electrodes; for large groups and pain in many nerve filaments, use large, well-moistened sponge electrodes.

Salt is to be added to the water only in Galvanization of face and head. In neuralgias of the extremities, use powerful currents. In Galvanization of the head, the *seance* should not exceed five minutes; in neuralgia, a longer time; in sciatica, about fifteen minutes repeated every four hours; in Faradization, five to fifteen minutes twice daily.—*Rocky Mountain Med. Review.*

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“Who shall decide when doctors,” &c. The medical profession is *Jennerally* represented as disinclined to be hand and glove with Dr. Kidd. This is a *Qaint* way of putting it.—*Punch.*

## PAIN AND ANODYNES.

Dr. Roberts Bartholow, of Philadelphia, says: "Several elements enter into the composition of pain—the peripheral irritation, the transmission of the impression to the centre, and its realization by consciousness. Hence, pain may be relieved either by interrupting its transmission to the centres of conscious impressions, or by suspending the functions of these centres. For example, aconite and gelseminum relieve pain in the former manner, and the anæsthetics in the latter. The anæsthetics, when applied locally, however, have an effect similar to that of aconite, and are, therefore, antagonistic to both peripheral and centric neuralgia. When a few minims of chloroform are injected into the neighbourhood of a nerve-trunk, the peripheral expansion of the nerve is put into an anæsthetic and analgesic condition; and since he introduced this method of treating sciatica, cervico-brachial and intercostal neuralgia, coccygodynia, and other neuralgias of nerves in accessible situations, his experience has been extremely satisfactory. The needle must be inserted deeply, since merely to inject chloroform under the skin, like morphia, is perfectly useless in such neuralgias, unless the nerve-trunk is in the immediate vicinity. No danger attends this expedient, and inflammatory induration and abscesses very rarely result from it.

The most powerful means for relief of pain which is now in our possession—the subcutaneous injection of morphia and atropia together—is an illustration of the advantages derived from the study of physiological antagonism. By this combination the anodyne qualities of the two agents are enhanced, rather than diminished, while the disadvantages of each are in a great measure obviated. The combined use of morphia and atropia is, also, the best preventive of the tendency of anæsthetics, like chloroform and ether, to produce fatal paralysis of the heart or lungs; while the prescription of atropia simultaneously with chloral to a great extent averts the dangers that sometimes attend the use of that agent.—*Cincinnati Medical News*.

## CAPSULES.

The invention of the capsule may be regarded as one of the triumphs of modern pharmacy.

The old-fashioned naked pill, with its irregular contour and its nauseous taste, which not infrequently excited in the pharynx an inverted deglutition, whereby the disgusting intruder was tossed up into the region of the posterior nares, there to remain fixed until the unfortunate swallower should dislodge it by vomiting, has become almost, if not quite, a thing of the past.

The capsule has manifest advantages over the pill, such as ease in swallowing, readiness of solution, together with the protection it affords the medicine against atmospheric influences, thus insuring that it shall arrive in the stomach in the best condition for assimilation; and the facts being well understood by the physician, the term, "*Ft. pilulæ*" at the close of a prescription is not now very often seen.

A capsule to meet the above requirements should consist almost entirely, if not wholly, of pure gelatin, which, on entering the stomach, appropriates water of composition, and becoming a jelly will readily dissolve and set the contained medicine free.

But the increased demand for capsules, together with a desire to furnish them at a low price, has tempted some manufacturers to use glue and various other cheap and impure compounds in their manufacture.

Capsules made of these substances are sometimes so slow of solution as to seriously delay the action of the medicine, or worse still, resisting the fluids of the alimentary tract to the end, pass out like bullets, unchanged.

Even if they be retained and dissolved they are competent to make mischief, for they carry with them the seeds of fermentation, which they germinate to the prejudice of a delicate digestive apparatus.

Before ordering them for a patient the physician should test a given specimen of capsules by holding one in his mouth until it dissolves. If its solution is rapid, and no unpleasant flavour is perceived, it may be safely used; but if it tarries long upon the



tongue ; or imparts to the taste a savour of the hide store or the sour paste pot, it should not under any circumstances be given to a sick person.

The old and highly reputable firm of H. Planten & Son, 224 William Street, New York, furnishes an article which will stand any test, and we can conscientiously recommend their capsules to the profession.

They are made of seven different sizes for the mouth and of three for the rectum. The latter are conical at one end, and present a form which may be easily introduced into the rectum, and retained by this organ without discomfort.—*Cincinnati Medical News*.

A GENEROUS TRIBUTE.—Sir,—I send enclosed an extract from a child's book recently published by J. F. Shaw & Co., Paternoster Row, as it contains a deserved tribute to our profession, which I think is rarely now to be found, for insertion in the JOURNAL, if you consider it acceptable.—Yours faithfully, M.D.

Extract from "*Froggy's Little Brother*," by Brenda, page 162.—"I am anxious here to pay a tribute to doctors, for it seems to me that, as a class, they shine out more brilliantly than any other men. Their patience, their kindness, their zeal, their devotion, their courage, who has not proved it for themselves at some time or other in their lives, or else heard of it from others? How the poor invariably speak of them, and who better than they can testify to their real worth? I often think what a bright array of doctors there will be in that day, when all the great things done in the dark shall be known in the light, and the army of the world's true heroes shall appear before the great white throne in heaven. How many a poor obscure country doctor, whose homely gig and hop-and-go-one horse have been the laugh and joke of the squire and his friends, when they have met him going his weary round on a sunny September morning, when they have been striding over the stubble with dog and gun, will be found in that day the better man of them all, amongst the little band 'who are unknown here, but well known there,' for deeds of gallantry and true heroism which this world passes by, but which will gain the highest honours and the brightest crown in the Paradise of God."—*Brit. Med. J.*

## DR. BOWLES ON STERTOR.

The general conclusions which may, I think, be fairly deduced from the present communication are :

1. That a "laryngeal stertor" may be added to the three forms I formerly defined.

2. That the three forms of stertor which have a most important connexion with the apoplectic state are the palatine, pharyngeal, and mucous stertor.

3. That these three varieties, whatever their remote cause, are the immediate result of a local mechanical condition—a condition which may always, and at once, be changed, to the great relief of the patients, and sometimes to their permanent recovery.

4. That it is necessary to keep the patient on one side, and the paralyzed side should be downwards.

5. That mucus and other fluids gravitate into, and fill up the lower lung ; and therefore that if the sides be reversed the mucus will find its way into the opposite lung.

6. That the fluid, crossing from the large bronchi of one lung to those of the opposite, becomes churned into foam, and causes dangerous obstruction to the respiration.

7. That the lung is not injured by remaining inactive and filled with mucus for a long period.

8. That these principles apply to all conditions allied to the apoplectic, whether there be mucus or not.—*London Lancet*.

## REMEDY FOR MIGRAINE (HEMICRANIA).—

*Pulvis antihemicranicus imperialis.*

R Quinidiæ sulphatis . . . 1.50 gm. = 24 grs.

Caffeinæ . . . . . 1.00 " = 15 "

Acidi tartarici . . . . . 1.00 " = 16 "

Morphiæ puræ . . . . . 0.05 " =  $\frac{3}{4}$  "

Sacchari albi . . . . . 10.00 " = 150 "

Mix and make into 5 powders.

One of these is to be taken morning and evening. Said to be a sure remedy in hemicrania. If necessary the quantity of morphia may be slightly increased. Feeble persons should divide each powder in two parts, and take both within an hour. Black coffee is the best vehicle for administering the powders.—

DR. HERMANN HAGER in *Pharm. Centralh.*

**BISMUTH PREPARATIONS.**—The Druggists' Circular reports that at the last meeting of the Kings County Pharmaceutical Society, the subject of impurities in the medicinal salts of bismuth first occupied the attention. Dr. Sheets related that, having had occasion to administer subnitrate of bismuth in his own family, the medicine caused great fetidity of the breath, persisting for several days (Oil and Drug News). He inquired if any one had observed any similar effects. Mr. Creuse answered that this garlicky smell had been noticed some time since in England, when it was attributed to the presence of tellurium in the metallic bismuth from which the salts were prepared.—*Louisville Med. News.*

**COMPOUND LIQUORICE POWDER.**—A recent writer in the *Philadelphia Medical Times*, Dr. E. T. Blackwell, proposes the name of *Pulvis sennæ compositus*, and the following formula:—

R Sennæ pulv .....  
Sulphuris loti .....  
Sacchari albi .....aa3ss  
Fœniculi pulv .....  
Glycyrrhizæ pulv .....aa3ij. M.

**IODIZED COD-LIVER OIL.** (*Foussagrives.*)—

Pale Cod-liver Oil, 100 grammes.  
Iodoform, 0 gr., 25 centgr.  
Essence of Anise, 10 drops.  
Mix.

The addition of the iodoform and anise masks in great part the taste of the cod liver oil, which is found also to contain one centigramme of metallic iodine to the spoonful. To patients who make use of ordinary cod liver oil, the author advises to add to the oil a small quantity of cooking salt, which modifies its disagreeable taste and facilitates its digestion.—*L'Union Médicale.*

The Medical Students of McGill College are establishing for themselves a museum of *Materia Medica*. The specimens of all the drugs in use, are to be kept in the Library of the McGill Medical Society, where students may examine and study them at their leisure.

## Surgery.

### TREATMENT OF CARBUNCLE.

SOCIÉTÉ DE CHIRURGIE—SESSION OF APRIL 6TH, 1881—PRESIDENCE OF M. DE SAINT-GERMAIN.

M. Marc. Sée has given up the treatment by Curage, which consists in first incising the carbuncle, and then removing its contents with the cutting spoon, substituting for it the method of which he had spoken at the last session. The claim made, touching this method, by M. Tillaux in favour of M. Alphonse Guérin, is not justified, M. Guérin having proposed a subcutaneous crucial incision, which, as regards the discharge of septic liquids, gives no better results than ordinary incisions.

M. Tillaux, referring to the opinion expressed by Nélaton, thinks that we should abstain from intervention in the treatment of anthrax, unless it be very painful. The opinion of Nélaton, in fact, is that incisions augment the irritation, and that it is necessary, on the contrary, to remove all irritating causes. These reasons are not of a convincing nature to us, and besides, such is not the opinion of most authors. Chassaignac, considering the cores as foreign bodies, thinks that the expectant plan exposes to the greatest dangers. Follin, not less categorical, is not content with incisions, but also has recourse to caustics. Billroth recommends equally a very energetic treatment, and is a partisan of numerous early incisions. These citations could be multiplied. To sum up: incisions are necessary which allow the discharge of the cores. This is why M. Sée prefers the treatment of which he has spoken, which has, in addition, the advantage of permitting antiseptic injections.

M. Labbé is struck by the fact that most surgeons each give a particular treatment of anthrax. Some are in favour of large incisions; others, of subcutaneous incisions; others, of multiple incisions; others, with M. Richet, are in favour of going beyond the limits of the disease and touching what this surgeon calls the subanthracoid phlegmon; others, with Broca, propose ablation, as if for a malignant



pustule; others, finally, are for abstention. For my part, I believe that each of these opinions finds its indications in the treatment of carbuncle, which takes on very diverse forms. From a clinical point of view, in fact, there are some carbuncles which it is unnecessary to touch; there are some which must be treated by M. Alphonse Guérin's method; others which call for multiple incisions; and, finally, others which ought to be removed, as Broca proposed. In fact, on the nape of the neck, for instance, there is a large anthrax, presenting multiple openings, whose tension is not very great and upon which it is sufficient to exercise slight pressure to cause pus to ooze out. In these cases poultices suffice, and the patients always recover whatever may be the treatment. There is a variety akin to this for which one incision suffices, or the method of M. Guérin. There is another which offers a great hardness and for which Guérin's method is not sufficient—great incisions must be had recourse to, large, deep, and multiple; the eliminating surfaces must be multiplied as much as possible. M. Boinet has obtained good results from injections of iodine in conjunction, in these cases, with the incisions. Finally, there are carbuncles which I call woody, and which are of such gravity that patients die if we intervene too late. These are the carbuncles which offer a tissue so resistant that the bistouri can scarcely cut them. I have formerly lost patients who I would not lose to-day, because I have recourse now in these cases to ablation, such as Broca proposed, as if we had a malignant pustule to deal with. There is then, to sum up, a certain number of varieties of anthrax which claim each a different treatment.

M. Desprès does not agree with M. Labbé on the point that there are cases in which the best treatment is by ablation. Furthermore, he is not a partisan of multiple incisions or tulip incisions, such as Velpeau practised. There are cases, in fact, in which these incisions have been followed by a mortal phlegmonous erysipelas. M. Desprès has treated in the city three large carbuncles, and in hospital forty-nine carbuncles, from the volume of an egg to that of the two hands. In eight grave cases, he

has only had two deaths in two diabetics; all the others recovered. Now, M. Desprès has never made incisions; and he is convinced that, in the statistics of his colleagues, the number of deaths is augmented by those which are due to the complications resulting from the operation. The incision, in fact, however large it may be, does not produce elimination of the eschar. Abstention is then, for M. Desprès, the best treatment of anthrax. He admits, however, that incisions may be made in points very clearly fluctuating, but from the tenth to the fifteenth day, and not from the third to the fifth day, as most surgeons state. These preventive incisions are of no use, and the patients who have recovered after these incisions have recovered in spite of them.

M. Trélat.—M. Marc Sée in wishing to trace simply an historic point has opened a pit fall by raising the question of the treatment of anthrax. I myself hold to what I have written in the article "Anthrax," in the *Dictionnaire Encyclopédique des Sciences Médicales*, viz., that there exist many varieties of anthrax—some very grave, others without the slightest gravity, and that each of these varieties calls for a different therapeutics. I do not believe that we are more authorized to say that incisions are always necessary, than we are to affirm, with M. Desprès, that they should never be made. There is no definitive therapeutics of anthrax; it is only a question of indications to fulfill. There are cases, indeed, in which large multiple and deep incisions are formally indicated; there are others for which the process of M. Guérin is preferable; there are some others to which it is necessary to join cauterization to the incision; there are some, finally, these last being much more rare, which claim the treatment proposed, but never executed by Broca.

M. Tillaux, replying to M. Sée, maintains that the method which he has borrowed from the Germans and that of M. Alphonse Guérin are similar, at least in their prevailing idea. Some years ago, each time that I found myself in presence of an anthrax, I hastened to split it in four or in eight. I have given up that manner of acting, and experience has led me to follow another line of conduct. There are

some carbuncles, those of the neck more particularly, for which preventive incisions are useless, the anthrax continuing to be developed and extending from the occipital curved line to the seventh vertebra, and from one mastoid apophysis to the other. In these cases incisions are useless, and cause the patients suffering. But there is another variety of anthrax, extremely painful, and in which large incisions, made at a certain moment, alleviate the patients greatly. These are the only ones which I now open; as to the others, I respect them, like M. Desprès.

M. Labbé recalls that, towards the end of his career, Nélaton used to say that anthrax should always be incised. While admitting that there are varieties of anthrax which may recover without incision, I maintain there are others where it is the duty of the surgeon to interfere, and to interfere as largely and as radically as possible; and there are many patients whose death I deplore, and whom I would have certainly saved had I acted as I would act to-day.

M. Marjolin.—The respect which M. Desprès professes for the ancients causes him to neglect the progress of modern surgery. The erysipelas of which he has spoken is not always the consequence of the incision. It as often manifests itself before all intervention. I cited at the last session, an example of the good effects of the large and deep incision. I will cite another: I incised, crucially, a large anthrax of the neck in a coal-heaver of the environs of Paris. The anthrax, nevertheless, pursued its course. I was recalled by the physician, and, seeing that my first incisions had not sufficed, I gave two new sabre cuts to this patient, who cried, "Murder!" but recovered very well. I have had an anthrax myself, and remember to have been much relieved by the incision. It is not necessary, then, for M. Desprès to attribute to the incision the death of the patients who have succumbed to their anthrax.

M. Verneuil.—I do not understand how one can say, in speaking of the treatment of anthrax, it is necessary to do this; or it is necessary to do that. There is not a year that I do not deliver three or four lectures on the treatment of anthrax. I am of the opinion

of M. Tillaux—in one hundred cases of anthrax there are, perhaps, eighty which do not require to be touched. I have often had occasion to compare the progress of anthrax in two patients who entered simultaneously into my service; the one having been crucified in the city, the other having undergone no incision. It was always this latter who recovered the more quickly. We may then say, that four out of five cases of anthrax should be abandoned to themselves. But from that to say they should never be incised! It is necessary to incise carbuncles when they are painful, and when they do not limit themselves. As to the diabetic anthrax, we save only those that we incise, the diabetic anthrax having a great tendency to diffusion. Then, for diffuse anthrax, the relieving constriction by cauterization with the thermocautery has always given me marvellous results. I have by this operation brought the moribund back to life. This is how I proceed:—I make with the thermocautery rays, like those of a carriage-wheel, exceeding by a full centimetre the limits of the disease. This is an operation which takes twenty minutes; so I take care to anesthetize the patients. From that very day the vomiting, the fever, and the delirium subside. This is a treatment of extraordinary power. There is no hemorrhage. I have recourse afterwards to antiseptic dressings. As to the small, or very painful anthrax, the subcutaneous incision of M. Alphonse Guérin seems to me an operative subtlety. I do not understand the necessity for it.

To sum up: the painless and limited carbuncles recover of themselves without incisions; but interference is formally indicated in painful, diffuse and diabetic carbuncles.—*Gazette des Hôpitaux*.

· ANOMALY—FOUR TESTICLES.—Dr. Cebeira presents a singular case—a soldier with venereal chancres, buboes, etc., and a scrotum having four distinct testicles—two in each sac—of different sizes. The supernumerary testicle of each side was above the other. The venereal diseases of the patient seemed to be in proportion to his testicles.—*Revista de Catulima*.



THE DIFFERENTIAL DIAGNOSIS OF FRACTURES AND DISLOCATIONS OF THE FEMUR AT THE HIP-JOINT,  
 TABULATED BY H. AUGUSTUS WILSON, M.D., LECTURER ON FRACTURE-DRESSINGS IN THE PHILADELPHIA SCHOOL OF ANATOMY.

	INTRA CAPSULAR FRACTURE.	EXTRA CAPSULAR FRACTURE.	ILIAC DISLOCATION.	SCIATIC DISLOCATION.	PUBIC DISLOCATION.	THYROID DISLOCATION.
1. AGE.	Most apt to occur in advanced life, after 55 years.	May occur at any period of life.	Adult life.	Adult life.	Adult life.	Adult life.
2. CAUSE.	Usually result of slight cause.	Usually direct and severe violence.	Always severe violence.	Severe violence.	Severe violence.	Severe violence.
3. CONDITION OF LIMB.	<i>Shortening</i> ; at first slight, but apt to increase to 2 or 2½ inches. Readily effaced by extension, but recurs on discontinuance.	Great <i>shortening</i> at first, which continues about 1½ to 2 inches. May be effaced, but recurs on discontinuance of extension.	<i>Shortening</i> 1½ to 2 inches. Only effaced by reduction. Does not then return.	<i>Shortening</i> ¾ to 1 inch. Only effaced by reduction. Does not then return.	<i>Shortening</i> ¾ to 1 inch. Only effaced by reduction. Does not then return.	<i>Lengthening</i> 1½ to 2½ inches.
4. CREPITATION.	Indistinct.	Very distinct.	None.	None.	None.	None.
5. MOBILITY.	Preternatural.	Preternatural.	Immobility in a fixed and constrained position.	Immobility in a fixed and constrained position.	Immobility in a fixed and constrained position.	Immobility in a fixed and constrained position.
6. POSITION OF KNEE.	Everted.	Everted.	Overlaps its fellow.	Inverted.	Everted.	Stands out and away from its fellow.
7. POSITION OF FOOT.	Strongly Everted.	Everted.	Inverted; big toe pointing towards opposite tarsus.	Inverted, big toe pointing towards great toe of opposite side.	Everted.	Straight.
8. POSITION OF GREAT TROCHANTER.	Moves freely, with leg, as it were, on a pivot.	Preternatural Mobility.	Higher than normal.	Higher and further back than normal.	Higher and nearer median line in front.	Lower than normal.
9. POSITION OF GLUTEO FEMORAL CREASE.	Nearly normal.	Higher than normal.	Higher.	Higher.	Higher.	Lower.
10. POSITION OF HEAD OF FEMUR.	Cannot be distinguished, except in very thin persons.	Cannot be felt.	Can be distinctly felt on dorsal surface of ilium.	Is buried in Sciatic foramen; cannot always be felt.	Easily felt over pubes.	Is in Thyroid Foramen. Can sometimes be felt.
11. VACUITY.	No vacuity over Acetabulum.	No vacuity.	Vacuity.	Vacuity.	Vacuity.	Vacuity.

**ATROPIA IN CHLOROFORM-ANÆSTHESIA.**—In reference to the communication on the above subject by M. E. A. Schäfer, a correspondent states that the subject has been for some years worked out by Professor T. R. Fraser, of Edinburgh, who has shown atropia to be a cardiac stimulant, advisable when chloroform is to be given. It stimulates the heart, not only indirectly, by lowering the conductivity of the cardiac terminations of the vagi, and thus, of course, diminishing their inhibitory power, but also directly, by stimulating the intramural motor ganglia of the heart; and possibly, also, by raising the excitability of the accelerator nerve to the heart from the cervical sympathetic ganglia; and, perhaps, it may even stimulate the cardio-motor in the medulla oblongata. Dr. Fraser considers it advisable to combine with the atropia a little morphia, say 1-120th to 1-60th of a grain of sulphate of atropia, *i.e.*, one to two minims of liquor atropiæ sulphatis (*B. P.*), and one-twelfth to one-eighth of a grain of acetate or hydrochlorate of morphia. These are injected about fifteen or twenty minutes before the administration of the chloroform is begun; and by this means, (1) not only is the patient in a less nervous state when the inhalation is commenced, but (2) less chloroform is required, and, (3) moreover, a very objectionable evil is got rid of, or, at all events ameliorated, *viz.*, the emesis which is apt to occur with chloroform. In the cases in which our correspondent has seen this method followed there has been no vomiting whatever, although in some the inhalation was considerably prolonged.

*A New Abortive Treatment of Erysipelas* in the April number of the *Archives of Dermatology*, Dr. L. Heppel, of New York, makes known a new abortive treatment of erysipelas which he has so far known to be successful in seven cases. It consists in "brushing the boundary line and the parts extending a finger's width on either side of it, with a ten per cent. alcoholic solution of carbolic acid until the integument thus painted shows a decided discoloration." An agreeable sensation is said to be experienced at the points of application.

**AN ENERGETIC ANTISEPTIC.**—A very powerful antiseptic has been found in eugenol, a sample of which has recently been introduced by the President of the Liverpool Pharmaceutical Society. As well as being a very active antiseptic, it is also recommended as an excellent remedy for toothache. It is not difficult to understand both these properties, as oil of cloves, from which it is obtained as well as oil of peppermint, is a well-known preventative of germs forming in paste, starch, ink, etc., and the oil of cloves has long been a popular remedy for toothache. It was also recognized as eugenic or caryophyllic acid, having a formula  $C_{10}H_{12}O_2$ , and forming salts with bases.—*Monthly Magazine.*

**SOOTHING OINTMENT.**—Dr. McCall Anderson gives the following as the most valuable application for inflamed surfaces that he has ever tried:—

R Bismuth oxyd .....	25·0
Acid oleici .....	200·0
Ceræ alb .....	75·0
Vaselini .....	225·0
Ol. rosæ .....	0·25

—*The Specialist.*

The following old-time advertisement clipped from a paper of Shakspeare's day, thoroughly establishes the position of the every-day practitioner of that period:—*Wanted*—In a family who have bad health, a sober, steady person in the capacity of doctor, surgeon, and man mid-wife. He must occasionally act as butler, and dress hair and wigs. He will be required sometimes to read prayers and to preach a sermon every Sunday. A good salary will be given.—*Whitaker's Physiology.*

In a very old number of the *London Gazette*, is found the following epigram, referring to the physicians of King George:—

"The King employed three doctors daily,  
Willis, Heberden, and Baillie;  
All exceedingly skillful men,  
Baillie, Wallis, and Heberden,  
But doubtful which more sure to kill is  
Baillie, Heberden, or Willis."



## Midwifery.

### PREVENTION AND TREATMENT OF MAMMARY INFLAMMATIONS AFTER DELIVERY.

BY W. H. TAYLOR, M.D.,  
Cincinnati, Ohio.

The *cause* of the lesion is the child's sucking, in which act the child compresses the nipple between its tongue and the roof of the mouth and draws it into the mouth, thereby subjecting it to firm compression and tension, whereby the epithelium is abraded and minute fissures formed. As this process is repeated at brief intervals, no opportunity for repair is afforded, but at each successive period of sucking the laceration is enlarged. From the intense pain experienced by the mother the flow of milk decreases; the child consequently makes greater suction effort, with corresponding injury to the nipple; so that it is not rare to have the child vomit small quantities of blood which it has drawn from the abrasions. The act of sucking is so exceedingly painful to the mother that it is postponed till the distension of the breast with milk compels her to submit to its being performed. The long-deferred nursing, the traction by the child's mouth and the diminished flow of milk tend to increase the amount of blood in the gland, causing engorgement, an early stage of inflammation. The maternal heroism which prompts the mother to persist in nursing her child at such sacrifice to her own comfort, commendable though the spirit be, is fraught only with evil; for the conditions detailed are aggravated till the changes are such that suppuration of the gland is unavoidable.

Although we must recognize other influences—for example, cold, contusions, epidemic influences—as potential in the production of abscesses, yet I have sketched the most common history of such production.

The *treatment* of the fissures described is usually unsatisfactory. Medical literature shows a countless array of applications for sore, chapped, cracked, fissured, ulcerated nipples; and all, in my opinion, are of but little value; for, however great the remedial power of the application may be, it is rendered entirely nugatory

by the sucking of the child, by which the fissures are necessarily torn open, so that whatever progress may have been made toward healing is undone each time the child is applied to the breast. With such opinions of the causation of fissured nipple but two means of treatment seem applicable; the first, the use of a nipple-shield, by which the nipple is protected to a considerable degree during sucking, is sufficient in mild cases, but is of little or no use in severe cases. The only remedy on which I rely, and which is adapted to all cases, is entire cessation from nursing with the affected nipple for from forty-eight to seventy-two hours, during which time the process of repair being uninterfered with by the child, healing will so far have progressed as to allow nursing with little or no suffering. Such suggestion usually awakens protest, on two grounds; first, that discontinuance of the use of the breast for the period mentioned will result in permanent cessation of the flow. While I cannot deny its occasional occurrence, yet such result is exceptional. Usually the flow will be re-established in a short time after re-applying the child to the breast. But even if the danger of such cessation were great, the treatment is still to be advocated, for we shall thereby probably avert suppuration, when nursing must necessarily cease and other evils increase.

The second ground of opposition to the advice given is that cessation from nursing will lead to accumulation of milk in the breast, and that such accumulation will result in abscess. That cessation from nursing will lead to temporary induration of the breast is a matter of daily observation. That suppuration is likely to result from this accumulation of milk alone I do not admit. I say from such accumulation *alone*, for I believe the means resorted to to overcome it often lead to the apprehended evil. To guard against the anticipated ill consequences of cessation from nursing, it is usual to resort to artificial means for removing the milk from the breast. I am persuaded that from these efforts the evils are greater than from the accumulation of milk. When we remember that irritation of the nipple by the child's mouth is the natural means for exciting the secretion, it is obvious that the effort to remove the accumulation by drawing

the nipple is unphilosophic and will be unsuccessful. Again: the use of various mechanical appliances, breast-pumps, etc., is often productive of serious injury by contusing the portion of the breast compressed by the instrument, and may possibly induce abscess.

With such views of the action of these appliances I discard them entirely and forbid all effort to remove the milk by suction. That it is desirable to relieve the tension of the breast which occurs for a few hours after nursing has ceased, must be recognized by all. For such purpose I have the breast very gently stroked with the hand with camphorated oil, the movement always being from the periphery toward the nipple. The effect of such manipulation continued from ten to fifteen minutes will be to cause the milk to flow. I seek to divert the the blood from the breasts and to deplete by giving a saline purgative. If the pain be severe enough to demand anodynes I give Dover's powder, because it both relieves pain and relaxes the engorged tissue. With management the fissured nipples heal, and threatened abscess is generally averted. That such happy result is always obtained can be said of no plan of treatment.

When suppuration seems inevitable our only course is to hasten it, and while awaiting the progress of the case to mitigate discomfort. As a very important means of relief I urge support of the breast by means of a broad bandage passed under the breast and around the neck. By this means we relieve the upper part of the breast and the skin over it of the continuous dragging sensation consequent on its increased weight, and also facilitate the return of blood from the breast, thereby lessening the engorgement of the breast. If this support does not relieve the pain sufficiently I administer opiates freely.

Dr. J. S. Parry, following McClintock, advises late opening of abscess of the breast, and I am inclined to adopt the practice. When discharge is effected, as perfect antiseptic dressing as possible should be applied. As soon after evacuation of the pus as the breast will tolerate pressure I resort to strapping, expecting thereby to prevent re-accumulation of pus, to obliterate the cavity and hasten union of the opposed sur-

faces, to compress the distended blood-vessels, thereby lessening the engorgement, and, by the continuous pressure, to stimulate absorption of effused material.—*American Practitioner and Walsh's Retrospect.*

#### A CASE ILLUSTRATING "MISSED LABOR."

At a recent meeting of the Obstetrical Society of London, Dr. Barnes stated that the term, "missed labor," proposed by Oldham, was not justified by the facts of Oldham's case; which proved on autopsy to have been one of extra-uterine gestation. Discussing other cases of presumed missed labor, accepting the arguments of Stoltz and Muller, the author affirmed that no authentic example of missed labor—this term being taken to mean the prolonged retention in utero of a fœtus, living, at term—is yet known. He cited examples of the retention of the ovum, which had perished in utero at pre-viable age, for some time, and notably until the arrival of the natural term of gestation. He related a case which came under his own care:—

A lady, aged thirty-nine, had borne three still-born children, the last of them five years ago, before consulting Dr. Veitch, at Penang, in December, 1872. Pregnancy dated from early in November preceding. The usual signs of pregnancy were manifest; she verified quickening; and up to the seventh month she felt movements of the child. About the eighth month, after a slight accident, a flow of blood came. Three weeks later another bleeding occurred, but no labor pains. Eleven months after the presumed date of conception she came to England. There was an impression that she might be suffering from fibroid of the uterus. She came under the author's care in December, 1873. Under chloroform, the cervix uteri having been dilated by laminaria tents, he felt what he took to be the interior surface of the uterus; the sound passed six inches. In January, 1874, some colored discharges went on. Pieces of bone, which turned out to be bits of the spinal column, passed by vagina. After dilatation by tents, more bones were removed by fingers and forceps. In February this manœuvre was repeated, and by craniotomy-



forceps the remaining parts of a fœtus, which appeared to have reached the eighth or ninth month of gestation, were extracted. Her health then improved, the discharges became less offensive, and the uterus gradually shrank, as in ordinary involution, but more slowly, until it reached the common conditions of the non-pregnant state, and the patient perfectly recovered. The author submitted that this was a clear instance of the retention of a fœtus dying in utero at a viable stage, for some months after the normal term of gestation had been reached; and that in this sense the term "missed labor" might apply.

**EXCORIATIONS AND FISSURES OF THE NIPPLE.**  
—Prof. Gio. Simula, 1880, Sassari, in a memoir on this subject, establishes the frequency of such troubles; 30 per cent. of nursing women being affected, according to Hinkel, 20 per cent. according to Schrader. The nipples are ordinarily affected in the first days of nursing, but rarely later on. The causes are generally want of cleanliness, aphthæ in the mouth of the children, and the continual suction, which acts, says Joulin, like permanent cupping; the nursing of a child several months old sometimes induces these troubles. The accidents are of gravity, or not, according to the intensity of the inflammation. The pain may be so excessive as to induce convulsions; the inflammation may extend to the mammary gland itself, whence abscess in this organ is accompanied by high fever. The nipple may be completely destroyed, and the resulting cicatrization prevent nursing thereafter from that breast. As preventive treatment, Professor Simula, prefers lotions of pure water to the astringent washes recommended by Trousseau and Cazeaux, which, in the end, he is persuaded cause the exfoliation of the epidermis. Against fissures of the nipple he recommends lotions of glycerine in a solution of bicarbonate of soda, (Startin). He considers the application of compresses wetted in pure water, over the parts, as the best treatment in these affections, allowing the child to nurse as seldom as possible.—*St. Louis Medical and Surgical Journal*.

## Correspondence.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

### COUNCIL EXAMINATIONS.

SIR,—Will you kindly permit me to express through your columns the regret that many medical practitioners feel at the ill-advised step taken by those students who have been unfortunate before the Council, in seeking comfort in the columns of the daily press?

There can be but one course to pursue for any one having a real grievance, in order to get redress, and that is to bring the subject before the notice of the Council in proper form.

There is no difficulty in doing so, nor from past experience can any one complain of harsh injustice in the rulings of the Council. It is certainly very questionable taste to vilify examiners, and publish insinuations, before the possibility of a proper investigation; while the prejudice thus excited may be fatal to that calm consideration the question merits. If any good whatever can proceed from the acrimonious correspondence the public has been lately treated to, it appears to the writer to lie in the propriety of the Council at its next meeting considering the advisability of doing what there is good example for elsewhere, that is, granting a supplementary examination each year to students who have passed in three or more branches, to take place three months after the first examination.

It is also to be hoped that the farce of holding examinations in two places may be done away with. The absurdity of the present state of affairs in this respect is too manifest to require more than passing notice. How would the College of Surgeons of England treat a proposal to have its examinations held in Oxford, or Cambridge, or wherever else there might happen to be a medical school? Yours, etc.,

Toronto, May 16th, '81. PRACTITIONER.

The *Medico-Chirurgical Quarterly* in noticing a doctor's removal intimates that at his new residence the gentlemen will continue to differentiate between specimens of diabetic urine and essence of sweet pea.—*Michigan Medical News*.

THE CANADIAN  
Journal of Medical Science,

A Monthly Journal of Medical Science, Criticism,  
and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, JUNE, 1881.

### MEDICAL COUNCIL EXAMINATIONS.

There was great excitement in Toronto, on the 2nd of May, among a certain class of Medicos, "when news of 'Sullivan's' victory came." On making inquiries, we found that about 57 per cent. of the candidates at the Council Examinations had been rejected, and we were very sorry to discover at the same time, that a few of the best students of the Toronto Schools were so unfortunate as to be included in the "black list." Some of these reached a high aggregate (from 70 to 80 per cent.), but came below 40 (or more correctly, under 38), on one subject, and in consequence, were rejected; not for the whole examination, however, but for that subject on which they received the low marks.

It adds a very unpleasant uncertainty to the results of examinations, when a certain number, who receive a high average of the marks should be rejected, while others, well known to have less knowledge, should be passed. There is, however, such an element of uncertainty in all examinations, which we must acknowledge, even though we very much regret it.

This year there appears to be a hardship in a few cases, and we think that in the future such accidents might be avoided, if the Council fixed a definite and reasonable rule, with reference to the standard required from the candidates. There has always been a mysterious vagueness about this subject. At one time 60 per cent. was required for a "pass without an oral," and now there appears to be some doubt as to whether 50 or 60 be the required percentage; and to add still further to the perplexity, the Examiners have (very properly we think),

assumed some discretionary power, and reduced the minimum to 40, or as low as 38. We think ample justice would have been done this year if the minimum had been reduced still lower. The Council might safely adopt the percentage required by our National University, i.e. 50 per cent. of an average on the aggregate, and 33 per cent. as the minimum on any one subject. This is considered a high standard, and certainly would seem so by comparison, when we consider the fact that it is only a few years since the Senate of Toronto University required simply 25 per cent. on all subjects. We believe, as a matter of fact, that such a standard is quite as high as is required for a simple pass, in any part of the world, and certainly higher than the average.

At the present juncture, having confidence in the honesty and ability of the examiners, we think the Council is bound to stand by their decision. Any other action would make the whole examination a sublime farce, and afford direct encouragement in the future to all rejected candidates to abuse, bulldoze, and "petition" against any examiners, who might have the temerity to pluck them, even though they richly deserved it. At the same time we would feel glad, if a special examination could be given, during the summer or fall, to those who obtained exceptionally high marks on the aggregate, but came a little below the mark on one subject.

One of the most unpleasant features of this excitement about the results of the examinations, is the fact, that grave charges have been made against Dr. Sullivan, of Kingston. There is always serious ground for suspicion as to the impartiality of a jury of rejected candidates, who meet in solemn conclave to discuss the merits of their examiners. We were deeply grieved to see in the daily papers a report of a meeting, held in Trinity School, on the 2nd of May, at which statements were made to the effect, that Dr. Sullivan had previously determined to pluck as many men from Toronto as possible, and conducted his portion of the examination with this object in view. The tone of the rejected was so extreme, that the public press of this city, both disapproved of it and ridiculed it. While duly respecting the feelings of candidates to whom the rejection was a matter



of very serious import, we feel sorry, that when deciding to petition the Council for favours, they should place themselves in a false position, by making unjust accusations against one of the Council's examiners.

In olden times we were accustomed to attribute deficiency in knowledge of the subject as a common cause of plucking, but such a contingency seems not to have occurred to the late rejected. They appear rather to have condemned Dr. Sullivan at once, when the results were known, and afterwards proceeded to search for evidence to prove his guilt. It is stated that paper with a different colour was used at Kingston, and in this way he was able to distinguish the Kingston from the Toronto men. In addition to this, we are told that the results show that the Kingston and Montreal men received higher marks in Surgical Anatomy than the Toronto students. From these facts, supposing them to be such, they jump at once to the conclusion, that Dr. Sullivan deliberately gave his own students high marks, and the Toronto students low marks, in order that he might pass the former, and reject the latter. If we supposed this to be true, we could only designate it as a criminal act, more malignant in character than any that has come under our notice in the history of examinations. If the members of the Council entertain any suspicion of the possibility of such a procedure on Dr. Sullivan's part, they can very easily investigate the matter by examining the papers of the different candidates, which, we suppose, are now in the Registrar's possession.

We published the final questions in our last issue, including those on Surgical Anatomy, and our readers can judge for themselves as to their character. No question is asked on any subject which is not taught in any ordinary course of Anatomy and Surgery. It is true, the students, who attended Dr. Sullivan's lectures on Surgery, may derive some advantage in being examined by their own lecturer; but even if we admit this, it does not necessarily follow, that the students of other schools, who knew their Surgical Anatomy should be rejected on a paper that contains no "catch" questions.

We now come to the important question in this discussion: Do our students pay sufficient

attention to the study of Anatomy? We know, to our sorrow, that in the past they did not, and we have reason to think that they do not even now spend sufficient time in the dissecting-room, where alone it can be properly learned. It is too much the fashion to rush through their dissections as rapidly as possible, and then depend on Gray, whose only redeeming quality lies in its excellent plates, while its general arrangement is as vicious as anything that could be conceived for the student, who wishes to learn his Anatomy perfectly, and has to undergo a practical examination on the dead subject. The schools are not at fault. Every facility is given to the students to dissect under thoroughly competent teachers, and while many make the most of their opportunities, others do not, because in the past they have found that they could manage to pass, and even get high marks by book-work alone. In the old countries, where the examinations are essentially practical, the students spend more time in the dissecting-rooms, in the first place dissecting themselves, and sometimes watching the work of others, receiving direct instructions from their demonstrators, and also listening to the demonstrations given to others. They continue at practical work up to the day of examination, on pickled specimens, dried specimens, wax or plaster preparations, skeletons, &c.

As a matter of fact, Anatomy can be taught here as well as in any place at the world, but a large number of our students pursue their studies simply with the dreaded examinations in view, and endeavour to get through these with a minimum amount of work. The Council, in their honest efforts to raise our standard, appear to have appreciated this fact, and decided to make the examinations thoroughly practical. Dr. Sullivan has, in our opinion, endeavoured to carry out the instructions he received faithfully and conscientiously. We regret the rather disastrous results, which, as before pointed out, we consider to be due to the high standard required, and to the fact that the students have not been accustomed to examinations so practical as those held this year. It should be remembered that Dr. Sullivan was not the only examiner who rejected candidates, as the following figures will show:

Among the finals, 31 were rejected in Surgical Anatomy, 15 in Practice of Medicine, 16 in Medical Pathology, 7 in Midwifery, and 5 in Surgery. After a consideration of these figures, it seems strange that only one examiner should be blamed, and we hope there is no truth in the rumour, that the students received any encouragement, either direct or indirect, from "high places," to make a personal attack on the honour and integrity of Dr. Sullivan. We have been unable to obtain the marks of the different candidates, and are, therefore, not in a position to discuss more minutely the merits of the question, but have felt it our duty to protest against the means adopted by those who doubt the impartiality of the examination. At the same time we would like to know how those numerous newspaper correspondents have been able to obtain so much information which has been denied to us.

We are glad to be able to say that the General Profession of this country most cordially approve of the efforts of the Council to improve the character of the examinations, and we hope they may be able to advance still farther, and in addition to the practical examinations in Anatomy and other primary subjects, institute Clinical Examinations in Medicine and Surgery.

UNIVERSITY SENATE ELECTIONS.—In the recent election the following gentlemen were chosen:—Messrs I. B. McQuesten, W. G. Falconbridge, and T. W. Taylor. We regret exceedingly the defeat of Dr. McFarlane, and why he should have been defeated no one seems to know, as it is generally acknowledged that he was one of the most efficient of the elected members in the Senate. By this action the number of Medical Senators is reduced from five to four, while it has generally been conceded that the fair proportion is five.

We have great pleasure in giving expression to the general consensus of opinion as to the efficiency and courtesy of the Medical Council's Registrar, Dr. Pyne, and at the same time have to acknowledge our personal obligation for his kindness on many occasions during the past year.

#### MONTREAL GENERAL HOSPITAL.

At a meeting of the Governors, held May 20th, Dr. Molson was appointed to the regular Staff, in the place of Dr. Reddy, resigned.

Dr. Gardner was placed on the Staff of the "out-door" department in Dr. Molson's place. The vote for this position was:—Dr. Gardner, 53; Dr. F. W. Campbell, 20; Dr. Reddy, jr., 9; Dr. Laphorn Smith, 1.

In accordance with a decision arrived at some time since, a new order of things has been instituted in the appointment of a Medical Superintendent, and Resident Assistants. Dr. James Bell has been appointed Medical Superintendent, and Drs. A. Henderson, of Montreal, J. A. MacDonald, of Panmure, P.E.I., and Frank H. Mewburn, of Drummondville, Ont., Resident Medical Officers.

It has been arranged to divide the attending Staff into Physicians and Surgeons, thus completing an arrangement, which for the last three years has been carried out with very satisfactory results, by Drs. Fenwick, Roddick, Osler and Ross.

DOMINION MEDICAL ASSOCIATION.—Dr. Canniff, the President of the Association, and others have been endeavouring to make arrangements with the railway and steamboat companies for reduced rates for physicians who attend the annual meeting which is to be held this year at Halifax, on Wednesday, the 3rd of August. The Minister of Railways, Dr. Tupper, has consented to give return tickets by the Intercolonial for a fare and one-third. The boat companies would like to have some idea of the number going before offering reductions. Those who intend going from Ontario are requested to send word to either the President, Dr. Canniff, of Toronto; the Vice-President for Ontario, Dr. Mullin, of Hamilton; or, the local secretary, Dr. Adam Wright, of Toronto.

MEDICAL COUNCIL ELECTIONS. — In the "Quinte and Cataraqui" division, Dr. Day, of Trenton, was elected by a majority of 45 over Dr. Tracy, of Belleville. In "Bathurst and Rideau," Dr. Cranston, of Arnprior, was elected by a majority of 32 over Dr. Killock of Perth.



## MEDICAL COUNCIL EXAMINATIONS.

THE following Candidates passed the Matriculation Examination for Medicine, April, 1881 :—

Geo. L. Johnston, Winthrop; Alex. McKillop, Crosby; Samuel McKeegan, St. Catharines; Duncan Gow, Wallacetown; Frank J. Dawson, Newmarket; John R. Logan, Trinity College School, Port Hope; Douglas Corson, Woodstock; C. A. Krick, Elcho; J. E. Midgley, St. Thomas; Elizabeth K. Beatty, Kingston; D. D. Ellis, Listowel; J. D. Dow, Pembroke; Jno. J. Sloan, Little Britain; A. R. Harvie, Orillia; F. C. Hood, Woodstock; J. N. Lannin, Willow Street, Toronto; Adelbert Hanna, Harlan; J. O. Orr, Aurora; F. W. Cane, Newmarket; J. H. Armitage, Newmarket; H. S. Birket, Hamilton; J. H. Kilgour, Mount Forest; J. W. Dougherty, Eden; K. W. McKay, St. Thomas; H. A. Wright, Toronto; D. M. DeCow, Dresden; H. Graham, Watford; R. J. Lockhart, Toronto; W. J. Gunne, Florence; C. F. Snelgrove, Toronto; C. J. McIntyre, Port Hope; K. A. Brown, St. Catharines; G. McDonald, Ingersoll; J. A. Watson, Toronto; J. C. Bell, Nairn; H. H. Hawley, Trenton; A. B. Osborne, Hamilton; A. J. Kippax, Brantford; E. A. Hall, Waterdown; Jno. MacDonald, Guelph; W. M. Brown, Woburn; H. C. Cunningham, Kingston; Angus Graham, Glencoe, Colfing; A. E. Stuart, Sandwich; J. F. Thompson, Binbrook; L. Carr, Ryckman's Corners; R. D. Hart, Wilfrid; A. R. Hawks, Clearville; G. M. Harrison, Dunnville; A. J. Hunter, Orangeville; A. J. Ercott, Merrickville; A. F. Little, Allandale; W. C. Cattnach, Cornwall; Osborne Totten, Paris; S. Morris, Strathburn; T. H. Mott, Mount Vernon; D. N. Carmichael, Manilla; W. A. Wilson, Markham; S. W. McConachie, Bowmanville; E. B. Robinson, Paris; F. H. Powell, Ottawa; H. R. Erskine, Ottawa; W. H. Murray, Galt; W. Donald, Goderich; Frank Beemer, Vittoria; J. J. Paul, Toronto; E. J. Eade, Kingsville; A. W. Campbell, Montreal; Nellie E. Reynolds, Toronto; T. B. Bolton, Toronto; G. C. Jones, Galt; W. A. Goodall, Galt; E. H. Bailey, Mount Forest; J. S. Freeborn, Galt; W. N. Robertson, Toronto; W. J. Mitchell, London; H. J. Mullen, Ottawa; J. E. Brown,

Tyrone; Geo. Fierheller, Sunderland; Peter Anderson Dewar, Kertch; Chas. Trow, Toronto; John R. Phillips, St. Catharines; M. C. McGannon, St. Catharines; Duke Kester, Brantford; B. S. Sheppard, London; W. J. Chambers, Paisley.

MEDICAL EXAMINATIONS.—Successful candidates passed by the Council of the College of Physicians and Surgeons of Ontario.—*Primary Candidates*—Allan, W. A.; Bedard, Eugene; Baugh, James; Burt, J. C.; Belt, R. W.; Bonnar, W.; Coulter, R.; Cameron, A.; Clendenan, G. W.; Collver, M. K.; Coughlan, R.; Denike, G. H.; Dowsley, G. C.; Eastwood, W. F.; Freel, I. A.; Gavillar, A. C.; Garrett, R. W.; Johnson, W. H.; Jarvis, C. E.; Johnston, Joseph; Jackson, J. M.; Lepper, W. J.; Meldrum, J. A.; McMahon, T. F.; McCausland, H. P.; Panton, A. C.; Rogers, S. R.; Robinson, W. J.; Rutherford, D. B.; Smith, A. D.; Snider, S. H.; Shore, J. E.; Stewart, J. M.; Wallace, R. R. *Third Year Candidates*—Bell, J. F.; Cleland, G. S.; Duncan, T. F.; Montgomery, D. W.; Rose, David. *Final Candidates*.—Aikins, H. W.; Alexander, R. F.; Berry, F. R.; Bingham, G. S.; Cameron, Paul; Clarke, J. G.; Duncan, J. H.; Emory, C. V.; Edmondson, W. C.; Fraser, H. D.; Gray, W. L.; Gibson, W. J.; Heyd, H. E.; Jones, A. C.; Jamieson, J.; Josephs, G. E.; Lennox, L. J.; Lavell, W. A.; Mearns, W. A.; Machell, A. G.; McGannon, E. A.; McLain, George; McGurn, J. S.; Oldham, E.; O'Shea, J. F.; Robinson, Jonathan; Reynolds, T. W.; Rogers, D. H.; Simpson, J.; Sweetnam, L. M.; Snow, W. H.; Tracy, W. J.; Woolverton, F. E.; Walker, John; Wilson, E. S.; Wallace, David; Wagner, G. C.

## TRINITY COLLEGE MEDICAL EXAMINATIONS.

—The following were the successful candidates in the final branches :—W. A. Allen, G. S. Beck, J. Baugh, C. W. Belton, T. G. Brereton, L. Bentley, M. L. Cameron, J. Ferrier, C. M. Freeman, A. H. Ferguson, H. K. Kerr, F. S. Keele, L. J. Lennox, Playter May, W. F. McLean, H. R. McGill, George McLain, H. P. McCausland, J. A. Macdonald, H. Mickle, W. F. Peters, R. Raikes, E. A. Spilsbury, J. Simpson, T. Sullivan, T. H. Stark, A. McC. Sloan, E. A. Stitt, J. C. Urquhart, J. Walker, F. E. Woolverton.

## THE TEACHING OF ANATOMY IN TORONTO.

In the slaughter of the innocents on the subject of Surgical Anatomy at the recent examinations, held by the Ontario Council of Medical Education and Registration, some misinformed, or wilfully blinded persons have affected to see a significant and injurious condemnation of the teaching of anatomy in this city. To our minds, however, and we have a personal cognition of the facts, the inference is far other, and both the cause and the remedy of the evil patent. It has been no secret for a long time past that our Canadian students, on visiting the Old Country, fell behind their English brethren only in the subjects of anatomy and physiology, being fully their compeers, if not superiors, in the other subjects of the curriculum. The reason for the decadence in these two particulars (for in the olden times of self-taught anatomy in this country our native students—among whom the names of Richardson and Bethune may be cited as honourable examples—did not fail to carry off the palm for the use of the scalpel in friendly strife with Old World men in Old World schools) was not far to seek when the respective modes of teaching came to be investigated. In recognizing the practical character of the one and the didactic of the other, and strenuously emulating, within the last five years, the good example of the Motherland, the University of McGill, and the Royal College of Kingston, have displayed their providence and wisdom, and compel us to exclaim with fervent approbation, "*Rem acu tetigisti!*"

Although comparisons are odious, and the appraising of the respective merits of men invidious, we do not hesitate to deny vehemently, in view of the fact that in the minds of some, our teachers of anatomy have suffered disparagement, that Dr. Sullivan is a better anatomist, or a better teacher of anatomy than Dr. Richardson. The latter's well-known indefatigable zeal in lecturing on his subject, his punctuality, accuracy and thoroughness; his high attainments in anatomy in the Old World; his eloquence, fervor and insistence, have combined to build him up a reputation throughout the Province of Ontario, and beyond it, which will

not pale in the presence of the brightest luminary of the scalpel.

Doubtless those who know best the Lecturer on Anatomy in Trinity Medical School, will be prepared to asseverate as much on his behalf. Such being the case, the inevitable conclusion is that anatomy is not less well taught in Toronto, than elsewhere; but that it is less well-learned, the result of the examination in question, appears to render undeniable. The simple remedy is: more personal dissection, longer and more assiduous patient study of the cadaver, forceps and knife in hand. Lectures on anatomy, however eloquent, the knowledge acquired, however painstakingly, from books and plates (being after all but aural instruction—the recital of what other men have seen) will not suffice; it is more fleeting than the moments in which it was acquired. Familiarity by sight and touch alone will secure the stamina and confidence so much needed at a practical examination. If Dr. Sullivan has succeeded in bringing home this cardinal fact to the minds of those most interested, he deserves well of them, of the profession, and of the community at large. For it is as true to-day as it was when that acute observer of men, the poet Horace, penned the lines:—

"Segnius irritant animos demissa per aures,  
Quam quæ sunt oculis subjecta fidelibus."

Dr. T. W. Mills, in a letter to the *Canada Medical and Surgical Journal*, says: "It gave my Canadian ears great pleasure to hear Dr. Coupland, in his lecture on Anæmia before the Royal College of Physicians of London, refer in the same breath to the investigations in the pathology of the subject by 'Pepper, Colucheim, and Dr. Wm. Osler, of Montreal, a member of this College.'"

Dr. A. H. David, on account of ill health, has resigned his position as one of the representatives, Bishops College, on the Medical Board of the College of Physicians and Surgeons, Province of Quebec.

ERRATUM.—In the first question in Medical Jurisprudence in our last, for "twins," read "burns."



ONTARIO MEDICAL ASSOCIATION.—We are glad to be able to announce that the first meeting of this Association is likely to be a very successful one. The provisional secretary, Dr. White, has displayed a wonderful amount of energy in bringing the question thoroughly before the Profession of the Province, and has received the most encouraging promises of cordial and hearty support from all quarters. The following are the subjects of some of the papers promised:—Aneurisms, by Dr. Cockburn, Oshawa. A case of Hip-joint Disease, of 55 years' standing, with Osteophytes. And "The Disposal of Sewer Gases," by Dr. Oldright, Toronto. Forward displacement and descent of Uterus, and description of new Anteflexion Pessary, by Dr. Rosebrugh, Hamilton. A case of Obscure Cerebral Disease, by Dr. Canniff, Toronto. Supra-pubic Lithotomy, by Dr. Groves, Fergus. Laryngeal Phthisis, by Dr. Palmer, Toronto. The Science of Medicine and Common Sense, by Dr. Curry, Rockwood. Progressive Pernicious Anæmia, by Dr. King, Toronto. A case of Epiphyseal Separation at upper ends of both tibiae, with plaster casts and photographs, by Dr. Powell, Edgar. Therapeutical uses of Sapo Viridis, by Dr. Graham, Toronto. Treatment of Night-Sweats, by Coto Bark, by Dr. Stewart, Brucefield. Notes on a case of Empyema by Dr. Yeomans, Mount Forest. — By Dr. Mackelcan, Hamilton.

Dr. William Smith Greenfield, late of St. Thomas' Hospital and Professor in the Brown Institution, has been unanimously elected to the chair of Pathology in the University of Edinburgh. He will conduct the class in Practical Pathology this summer, but will not enter on clinical medicine until the winter.

TORONTO MEDICAL SOCIETY.—The election of officers resulted in the election of Dr. Daniel Clark, President; Dr. Graham, 1st Vice-President; Dr. Oldright, 2nd Vice-President; Dr. Macdonald, Treasurer; Dr. Davidson, Recording Secretary; Dr. Sheard, Corresponding Secretary; Dr. Adam H. Wright, Dr. Lett and Dr. Spencer, members of the Council.

ST. THOMAS'S HOSPITAL OUT-PATIENT DEPARTMENT.—The public know but little of the vastness of the work done, in an unobtrusive way, in the out-patient departments of the various hospitals throughout London. We have received some statistics with reference to St. Thomas's which are of interest in this connection. No fewer than 76,605 cases in all were treated at that hospital alone as out-patients during 1880; of this large total, over 44,000 are set down to surgical casualties, while the cases of medical emergencies amounted in round numbers to 7,900. The out-patient physicians had over 6,000 cases, the out-patient surgeons over 4,000 cases, regularly under their care; and the obstetrical department was not less active, for nearly 4,000 women suffering from diseases peculiar to their sex were treated as out-patients; in addition, 2,122 women were attended in their confinements at their own homes, making an average of over forty such cases a week for the whole year.

We are pleased to announce that Dr. McPhedran, of this city, whose mastoid process Dr. Reeve, assisted by Drs. Rosebrugh and Oldright, found it necessary to trephine on the 19th ult., is progressing satisfactorily. The cells were not reached until three-fourths of an inch of bone had been traversed.

VICTORIA UNIVERSITY.—At the Convocation held in Cobourg on the 19th of May, the honorary degree of LL.D. was conferred upon Dr. Wm. T. Aikins, the President of the Toronto School of Medicine.

The degree of B. Sc. was conferred upon J. A. Clarke, M.A., M.D.; C.M. was conferred on G. B. Smith, M.D., H. Watt, M.D., A. W. Campbell, M.D., and J. V. White, M.D. In addition to those mentioned in our last issue, Dr. Thos. Chisholm, of Arthur, received the degree of M.D.

COLLEGE OF PHYSICIANS AND SURGEONS, PROVINCE OF QUEBEC.—At the Matriculation Examination held May 5th and 6th, there were 57 candidates, of whom 18 were successful, while 39 were rejected.

## Obituaries.

### GEORGE PHILIP DeGRASSI, M.D.

It is with much personal and general regret that we are called upon to chronicle the death of our old friend and fellow-labourer, George Philip DeGrassi, at the early age of thirty-nine. The cause of death was cerebral meningitis, perhaps consequent upon old middle ear disease. Dr. DeGrassi was the son of the late Alfio DeGrassi, a well-known resident of this city for many years, and grandson of the late Captain DeGrassi, who served in the Peninsula under Napoleon Buonaparte, and subsequently held a commission in the British service. To the British throne he and his descendants have ever been the most loyal of subjects. Dr. DeGrassi received the Baccalaureate, in Medicine, of the University of Toronto in 1862—securing the gold medal in the face of the keenest competition. After graduation he began practice in the village of Newbury, where he remained until the outbreak of the civil war in the neighbouring Republic, when he joined the army of the North. On his return to Canada, he settled in Toronto, where he resided and practised up to the time of his death. An active politician and a whole-souled Conservative, his absence from the election contests of the future will be greatly felt; a man of large proportions and handsome countenance, his familiar face will be much missed on his accustomed rounds; and at the sick-bed, those only who had personal experience of his kindness of heart and gentleness of manner will fully appreciate their loss.

We regret to announce the death, on the 21st of April, of Prof. Ludwig Waldenburg, of the University of Berlin. Dr. Waldenburg was Physician to the Charité Hospital, and Editor of the *Berliner Klinische Wochenschrift*. He had devoted much attention to respiratory affections, was the author of a treatise on the subject, and inventor of an apparatus for the inspiration of compressed air.

Dr. J. P. Nash, Mayor of Picton, died May 14th, at the age of 42.

Dr. Charles V. Berryman, at one time one of our most prominent and active practitioners in Toronto, died on the 2nd of May, at the age of 51. He graduated in medicine in the University of Victoria College, in 1857, and received the degree of M.A. from the same institution in 1861. He was lecturer on *Materia Medica* and Therapeutics for some years in Victoria Medical School, member of the Ontario Medical Council, from 1866 to 1880, and a Physician to Toronto General Hospital for many years. He also took an active interest in municipal matters in Yorkville, and held different positions in the Town Council.

Among the victims of the boating disaster at London, Ont., on the Queen's Birthday, was Oronhyatekha, aged 10, son of Dr. Oronhyatekha.

Dr. P. H. Bryce has returned from Europe and commenced practising in Guelph. Dr. Jno. Ferguson has also returned, and intends to settle in Toronto.

PERSONAL.—Dr. Reeve, of Toronto, sailed for England by the *Parisian* on the 21st of May. He expects to be away three months. Dr. Johnson, of Yorkville, has also gone for a trip to Europe.

Regarding compression of the ovaries in producing hystero-epilepsy, as discovered by Charcot, it is acutely observed by Kussmaul that if you take a man and squeeze his testicle hard enough you can make him have a spasm.

## APPOINTMENTS.

Dr. J. W. Lesslie, to be Assistant Surgeon "Queen's Own," Toronto; *vice*, Dr. Bethune, resigned.

Dr. H. E. Vaux, Assistant Surgeon, to be Surgeon "Brockville" Battalion of Infantry; *vice*, Dr. Wm. Mostyn, deceased.

Dr. H. A. Higginson, to be Assistant Surgeon, "Prescott" Battalion of Infantry; *vice*, Dr. Ewing, promoted.



## Book Notices.

*Announcement of the Bellevue Hospital, Medical College, New York, Session of 1881-1882.*

*Vox Humana; or, The Art of Singing, from a Medical Point of View.* By HERBERT JUNIUS HARDWICKE, M.D., Sheffield.

*Ninety-Eighth Annual Catalogue of the Medical School (Boston), of Harvard University, 1880-1881, Cambridge.* CHAS. W. SEVER.

*On Unnecessary Surgical Operations in the Treatment of the Diseases of Women.* By CLIFTON E. WING, M.D., Boston.

*Eighth Biennial Report of the Illinois Asylum for Feeble-minded Children, at Lincoln, Springfield.* H. W. ROKKER.

*Report of the Asylum for the Insane, London, for the year ending 30th Sept., 1880.* By R. M. BUCKE, M.D., Superintendent.

*Thirty-Eighth Annual Report of the State Lunatic Asylum, Utica, N. Y., for 1880, Albany.* Weed, Parsons & Co., Printers.

*The Illustrated Scientific News, for May, 1881.* Price \$1.50 per annum. Munn & Co., Publishers, 37 Park Row, New York.

*Question of Shortening in Fractures, Dr. Hamilton's Reply to Dr. Sayre.* (Reprinted from the N. Y. Medical Record.)

*Excision of the Rectum for Malignant Disease.* By N. SENN, M.D., Milwaukee, (Reprinted from "International Journal of Medicine and Surgery.")

*Transactions of the American Otological Society. 1880.*

This Report of the thirteenth annual meeting of the society contains in good form various interesting and instructive papers and clinical records, and is a fit companion volume to the Transactions of the sister society.

*Photographic Illustrations of Cutaneous Syphilis.* Forty eight plates from life, coloured by hand. By GEO. HENRY FOX, A.M., M.D., Clinical Lecturer on Diseases of Skin, College Physicians and Surgeons., New York. New York: E. B. Treat, 757 Broadway.

We are in receipt of parts 7, 8 and 9 of this most excellent work, containing plates xxv. to xxxvi. inclusive. The subjects illustrated are Syphiloderma Tuberculosisum, T. Ulcerativum, T. Squamosum, T. Crustaceum, T. Serpiginosum, Pustulo Crustaceum (Scrofuloderma Ulcerativum by way of contrast), and Syphiloderma Gummatosum. The high degree of artistic excellence attained in these plates, and their truthfulness to the living realities they represent disarm all criticism. We can only reiterate the commendation we have before expressed, and advise all who have not had the advantage (and even those who have) of a very wide clinical experience of the Protean phases of Syphilitic skin affections to acquire these very helpful plates in perplexing cases. The letterpress itself is well worth possessing.

*A Treatise on the Materia Medica and Therapeutics of the Skin.* By HENRY G. PIFFARD, A.M., M.D., Prof. Dermatology, University of the City of New York. New York: Wm. Wood & Co. 1881.

This work is the February number of *Wood's Library* for 1881; and constitutes quite a new departure in dermatological literature. An alphabetical order is adopted throughout both the materia medica and the nosological lists. Part I. consisting of 117 pages is devoted to the materia medica, and the following plan is observed: First, the name of the remedy is given together with that of the pharmacopœia (if it be pharmacopœial) in which it is found. Then follow brief statements of its effects upon the healthy skin when administered internally, and when locally applied, the therapeutic effects upon the diseased skin when medicinally ingested and on topical application. An appended figure also affords a reference to the bibliography which accompanies the work. This section although short is very complete and includes the latest as well as the earliest remedies for

skin diseases. Part II. comprising some 200 pages is devoted to therapeutics (electricity and cautery included). The plan pursued here is to take up the recognized affections of the skin in their alphabetical order, briefly note their definition and description, diagnosis, prognosis, and etiology and then deal *in extenso* with the treatment. The author's name is a sufficient guarantee of the thorough and scientific character of this part. We can only add the latest researches and most recent contributions to the subject appear not to have been overlooked. A fair formulary is appended but we see no notice of green soap.

*The Diagnosis of Diseases of the Spinal Cord.*

By W. R. GOWERS, M.D., F.R.C.P. Second edition, with additions and illustrations. London: J. and A. Churchill, New Burlington Street. 1881.

The first edition of the reprint of this lecture, delivered in 1879 before the Medical Society of Wolverhampton, was soon exhausted in consequence of the favourable notice it received at the hands of the medical press, and the admirable manner in which it was found to fill the great lacuna until then existing in English medical literature. Indeed, apart from Charcot's lectures on the Cord, we have not met with any work dealing so fully, philosophically, and lucidly with the intricate, and barely investigated subject of which it treats. Here we find set forth in brief, but with that lucidity of style and breadth of grasp which, in his other writings, have already made this youthful and accomplished author famous, the Medical Anatomy of the Spinal Cord, Its Physiology in relation to its Nosological Symptomatology; The Anatomical Diagnosis and the Pathological Diagnosis of the affections to which it is subject, together with the citation of illustrative cases; the whole made plainer by a score of wood-cuts and a coloured plate illustrating some ten sections of the cord in some of its more important lesions. Within the small compass of 84 pages the work covers so much ground that want of space forbids our following the discussion of the many controverted questions involved. Suffice it, e.g., to say that the section

on tendon reflex which was before imperfect and inaccurate has, in this edition, been rewritten and now certainly presents the most rational description and explanation extant. The term Tendon Reflex is condemned; and myotatic contraction suggested in its stead, it being satisfactorily demonstrated that the phenomenon depends on muscle reflex irritability alone. Few books have been published in recent times from which so many men will learn so much.

*The Hygiene and Treatment of Catarrh.* By THOMAS F. RUMBOLD, M.D., St. Louis. G. O. Rumbold & Co., St. Louis. 1881.

The author has for a number of years given enthusiastic attention to the elucidation of his favourite specialty; and we regret that the work in which he incorporates the results of his labours and experience should be marred by defects which are not trivial. In the first part, published separately a few months ago, the various hygienic and sanitary measures appropriate to catarrh are pretty fully considered. The baneful effects of tobacco on the naso-pharynx and tympanum are forcibly set forth. The author takes ground against the nasal douche, which he, in common with many others, has found to be often both ineffective and injurious; and he advocates the use of sprays, the snuffing of liquids from the hard sponge, &c.

In the second part, tubal and aural as well as naso-pharyngeal catarrh, with the therapeutic and operative measures involved, are considered. At various points the author steps out of the beaten track, and sometimes reaches conclusions which do not accord with the dicta of the authorities. He holds that the air continually permeates the Eustachian tube into the tympanic cavity, and that this passage is not open during deglutition; that the air in the tympanum is normally rarefied, causing the uniform concavity of the drum-head. Abnormal patency of the Eustachian tube is regarded as not infrequent, though too often unrecognized.

There is a good deal of useful and suggestive matter in the work, but its construction is bad, and the frequent allusions of the author to him-



self are distasteful. Moreover, the volume is replete with glaring violations of the simplest grammatical rules, which we would fain hope can be honestly laid upon the already burdened shoulders of that scape-goat, the proof-reader. For the credit of the profession, the author, and the publisher, an expurgated edition in much better dress is called for.

*A Treatise on Albuminuria.* BY W. HOWSHIP DICKINSON, M.D. Cantab, Physician to St. George's Hospital and Hospital for Sick Children, etc. Second edition. New York: William Wood & Co. Toronto: Willing & Williamson.

This excellent treatise forms the first volume of "Wood's Library of Standard Medical Authors" for 1881. As a writer on "Diseases of the Kidneys," Dr. Dickinson has been well known for many years. In this work he treats of tubal and diffuse nephritis, granular kidney, and lardaceous disease. His views on these subjects have not changed materially since the issue of the first edition in 1868, but he has elaborated some points more fully, and has rewritten some portions.

Two new chapters are found in this edition. One treats of the "Condition of the heart and arteries in chronic renal diseases." In discussing the theories as to the cause of the hypertrophy of the arteries and left ventricle, he discards entirely the view of Gull and Sutton, that these changes are simply part of a general condition, to which they give the name, "arterio-capillary fibrosis," and which they say is not due to renal deficiency.

He also objects to the idea of the existence of any antagonism between the heart and arteries with arterioles, as included in the "stop-cock" theory of George Johnson. He believes that this condition of the vascular system is caused directly by capillary hindrance to the passage of blood vitiated by imperfect renal action, thus accepting the essential points of the views enunciated by Bright many years ago. In the second new chapter on "Retinal Changes from Albuminuria," he describes serious infiltration, hæmorrhages, and the white spots of fatty degeneration, and considers that

albuminuric "retina" would be a more correct term than "retinitis," because the latter signifies an inflammatory process which is not usually associated with the changes described.

The author gives an exhaustive description of the diseases mentioned, including the opinions of others, and at the same time the results of his own extensive researches. He gives causes, symptoms, pathology, and treatment, and illustrates his views by reports of cases in such a way as to make the whole book thoroughly instructive and interesting. The numerous plates, many of which are coloured, add still more to the value of the work. Altogether, it is well worthy of the post of honour as the first in the series for the year.

*Syphilis and Marriage.* Lecture delivered at the St. Louis Hospital, Paris. By PROF. ALFRED FOURNIER. Translated by P. Albert Morrow, M.D. New York: D. Appleton & Co., 1, 3 & 5 Bond St. 1881.

Syphilis in marriage is a subject upon which every practitioner of medicine is bound to hold an intelligent and reasoning opinion. The circumstances in which he is liable to be called upon to formulate that opinion, and the momentous and far-reaching character of the issues involved must make him pause before reaching a conclusion based upon a limited individual experience. In the work under present consideration will be found the materials for a just decision, and, what is more, the clearly defined and enunciated views of a master who has devoted a lifetime to the subject, and viewed it in its every phase. It will not be a matter of surprise, therefore, that thoroughness of treatment, delicacy, tact and ingenuity in handling the subject are characteristics of the work. The subject is broadly considered under two chief conditions, viz.:—Before marriage and after. In the former, after disposing of certain preliminary questions, the following topics are successively considered, in so many chapters: Direct Contagion, Syphilis by Conception, Paternal Heredity, Mixed Heredity, Maternal Heredity, Personal Dangers of Husbands, Conditions of Admissibility to Marriage (Absence of Actual Specific Accidents—Advanced Age of

Diathesis), Prolonged Period of Immunity (Non-Menacing Character of Diathesis), Sufficient Specific Treatment, The use of Sulphur Waters. Of these it need only be said that each is treated with the universally acknowledged originality and ability of the author. The opinion is strongly stated that the simple fact of a man's once having had syphilis is not necessarily a bar to marriage; but the right to marry is hedged about with so many conditions of such rigour and exactness that few will, we believe, be found amongst the unfortunate in this country to comply therewith. The view that the offspring of syphilitic parents, even if not syphilitic, may present a debilitated constitution as a modified expression of the diathesis is ably maintained, and attention is directed to the occurrence, not sufficiently recognised, of sudden death in infants without apparent cause as a striking result of the intoxication. Meningitis, too, is mentioned as a common consequence. Before sanctioning the marriage of a syphilitic subject, our author exacts of him a delay of a "minimum period of three or four years devoted to a most careful treatment;" and although Mr. Jonathan Hutchinson, whose authority as a syphilologist the world acknowledges, has expressed the opinion in his preface to Lingard's English Translation of this very work, that in many cases this rule might with advantage be relaxed, yet we cannot but feel that in this respect our author pursues the safest course, and surely in this matter the safest course is best. Cerebral syphilis, or any tendency to an intracranial manifestation is regarded as an express interdiction of marriage. The test of the presence of syphilis by sulphur baths, and their reputed revealing action is characterized as a legend to be abandoned. The after-marriage aspects of syphilis are then considered from the point of view of Husband, Wife, and Child; and the "Dangers to Society" through nurses and nurslings are not omitted; after which fifty-six pages of notes and illustrative cases complete a volume of rare excellence and pressing interest to all classes of society. The translation, although many sentences are strangely Gallicised, is on the whole well rendered, and if our memory serves, presents a literal and faithful reproduction of the eloquent *leçons* of the learned Professor of Dermatology of the Paris Faculty, and distinguished Surgeon of the Hôpital St. Louis.

*Lectures on Diseases of the Nervous System, Especially in Women.* By S. WEIR MITCHELL, M.D., with five plates. Philadelphia: Henry C. Lea's Son & Co. 1881.

Under this title, Dr. Mitchell publishes a series of thirteen most interesting and instructive lectures. The subjects treated of are: The Paralysis of Hysteria, Hysterical Motor Ataxia, Hysterical Paresis, The Mimicry of Diseases, Unusual Forms of Spasmodic Affections in Women, Tremor and Chronic Spasms, Chorea of Childhood, Habit Chorea, Disorders of Sleep in Nervous Persons, Vaso-Motor and Respiratory Disorders in the Nervous and Hysterical, Hysterical Aphonia, Hysterical Gastro-Intestinal Disorders, and lastly the treatment of Nervous Exhaustion and Hysteria by Seclusion, Rest, Massage, Electricity and Full Feeding. All the chapters contain many practically profitable suggestions and directions, and are illustrated by the citation of curious and interesting cases which will doubtless help to elucidate many perplexing and obscure phenomena occurring in the future experience of others. The vernal seasonal occurrence of chorea, its urban predilections and more frequent occurrence in the white race, are well brought out, and the five plates are intended to illustrate the first of these topics. The storm area element in chorea appears to be analogous to that earlier observed by the author in neuralgia. The treatment of Hysterical Disorders by the author's plan as first set forth in his "Fat and Blood, and How to Make Them" has proved equally successful in the hands of Mary Putnam Jacobi, and other careful and accurate observers, and we can only recommend it to our readers' notice in the hope that they may thereby secure as good results in the management of these really distressing maladies. It would have been a matter of much interest to have had an account of our author's experience of hysterical temperatures. "The elements out of which these disorders arise are deeply human, and exist in all of us in varying amount, while many of the determining and conditioning factors come from accidental, or, at least, external agencies." Their manifestations are accordingly common—perhaps commoner than we recognise or suppose; and it behooves us, therefore, diligently to acquire what insight we can into their nature, causes, cure and prevention. We assure our readers that this last little book of Dr. Mitchell's offers to all a helpful hand in that direction.



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## Original Communications.

### THE PREVENTION AND DISPOSAL OF GASES INJURIOUS TO HEALTH.

BY WM. OLDRIGHT, A.M., M.D.

Curator of Museum and Lecturer on Sanitary Science in the  
Toronto School of Medicine.

(Read before the Ontario Medical Association.)

MR. PRESIDENT AND GENTLEMEN,—I will ask your permission to change to the above caption the title of my paper, thereby extending it so as to embrace the consideration, not only of sewer gases, but also of some sources of disease independent of sewers.

Some injurious gases reveal themselves unpleasantly to the nose, whilst others do not. These last are so insidious in their nature as to be doubly dangerous. As examples, I may refer to the baneful results which ensue from living in houses under which water lodges and becomes stagnant. There are, I believe, few of us who have not witnessed these results. The miasmatic poison of ague is similarly inodorous, or has no necessarily unpleasant odor. Sewers, also, have sometimes very little unpleasant smell. Sometimes we have a faint smell similar to that produced by those burning fluids into the composition of which fusel oil enters. People living in a house become so accustomed to these faint odors as to take little notice of them; and with some people the sense of smell is not very acute. Hence we must be very careful how we accept negative evidence as to the presence of noxious gases. And hence, too, we must be all the more careful to avoid their existence and presence, and to devise means to this end.

It is plain that to prevent the constant accumulation of noxious gases, we must get rid, as far as possible, of decomposable material before it begins to decompose; and must see that the noxious gases from any decomposing material do not reach us. How simple these two propositions are! And yet, in practice, how difficult of execution; but as the difficulty arises from the ignorance, and partly consequent carelessness, of others, we may accomplish much by constant vigilance and hammering away.

The principal decomposable materials are the waste and refuse of foods, the water for cooking and cleansing purposes, and our excreta.

1. The refuse of food should be disposed of in one of three ways:—

a. If we have domestic animals about us, they may eat most of it (and prepare it to come under the next heading, in diminished form.)

b. If we have no domestic animals, it may be removed to some more isolated region—into the country—for manurial or other purposes.

c. If this cannot conveniently be done, most of it may be burned at such time as our fires are not needed to be at their best.

2. Slop water should not be thrown out to saturate the soil of a semi-circle extending fifteen feet from the back door. This process is often persisted in year after year, under the pleasing delusion that "it all soaks away."

It may be better disposed of:—

a. By turning it into melons, grapes, and pumpkins. Gardens will thankfully receive, and render innocuous, a vast quantity of slop.

b. If the garden, or the gardener, be not at hand, it may be turned into a sewer.

c. Or conveyed by pipes or otherwise into a cesspool, covered and ventilated, and at some distance from the house.

d. Bedroom slops may either be disposed of in one of these latter methods, or may be absorbed into the manure heap, if the premises be extensive enough to admit of one without danger.

In coming to the disposal of fœcal excreta, let me at the outset protest against that reeking abomination, the privy pit, that disgrace to the progressive civilization of the nineteenth century. Some of these are cemented, exerting their poisonous influence only, or mainly, on the air, others are holes in the earth, poisoning both earth, air, and water. I wish every owner of such a nuisance could have pasted over his well, and if he still persists, then I would that he could have constantly impressed on his vision also, Teale's graphic picture of a section of a house, well, and privy vault, with a man standing by the pump, quaffing, with evident gusto, what he innocently believes to be pure water.

If we have a good system of sewerage, with proper outfall, we will find that the plan of having water-closets connected with the sewer system is the most practicable one, and even where there is not any more suitable outfall than our delightful Toronto Bay, the convenience of the water-closet system will cause those who can afford it to introduce it.

In other cases the dry system should be carried out, and it is very simple if people will only have more common sense and less disgusting sentimentalism. A small house is made without any pit, and with a seat resembling the one in common use only that its upper part is hinged so as to be raised up; underneath the hole a pail or box is placed; and in the corner a box of ashes and small shovel. The inmates soon get into the way of attending to the covering with ashes. When the box is full it is lifted by the handles and emptied into a barrel or ashpit, or if practicable removal takes place with sufficient frequency to render this storage unnecessary.

And now, to return again to our sewers; now that we have handed over to them many decomposing substances, how dispose of the

gases generated thereby. In the first place the materials of which drains and sewers are constructed, their course, their slope, the construction of their joints, the course of their junctions, the facilities for flushing them, all these points must be carefully considered with a view to carrying away the decomposing and decomposable material; but these points I shall not have time now to consider.

The main subject of this paper is how to dispose of the gases necessarily generated in the sewers.

Sewer gases are now disposed of in three principal ways:—

1. In a very large number of cases they are allowed to escape into the inside of dwellings. To such an extent is this the case that some sanitarians are disposed to banish the sewer system *in toto*.

2. In some instances they are supposed to discharge through gratings in the centre of the road bed.

But in many cases they discharge at the side of the sidewalk through the traps of gullies emptied by evaporation. Examples of this may be seen at many of our corners (*e.g.*, corner of Duke and Frederick) in winter time.

The ventilating gratings of sewers are so often clogged with dirt that they are of little value in disposing of the total amount of sewer gas.

3. In a few cases the sewer gas is discharged above the house-tops. I think very little consideration will suffice to show that this is the proper method and we must use our exertions to make it general.

By referring to the diagram which I show you, you will see that this can be accomplished by extending the soil pipe up to the roof.

It would be almost satirical to say that we ought to use all endeavours to prevent the first method of disposal; and yet the vast majority of people, professional and otherwise, act as if it did not matter much.

Let us then consider how sewer gases obtain entrance into houses.

1. In some cases there is no "trap," interposed between a drain or sewer, and the air respired by the inmates of the building served by that drain or sewer, no attempt at any



mechanical impediment to the return of sewer gas. This, of course, should not be the case. Some form of trap should be placed as near as possible to the proximal end of every waste-pipe. (*Here a variety of wet-traps were shewn.*)

I have also a "dry trap" with flap-valve and ingeniously contrived hinge; but as it cannot compare with the wet trap, properly vented, in point of usefulness and effectiveness for house purposes, for many reasons which I have not now time to point out, I will not take up your time with it, or other forms of dry-traps.

2. Where there are traps they are liable to be forced. Some think that if they have a trap all is right, but let me say that a trap without a vent outside of it is of hardly any practical value. A trap with a protecting depth of water (commonly called the "seal") of three inches (a three-inch seal) only resists a pressure of some two ounces to the square inch.

Now I hold in my hand a two-inch trap with a good seal, which I have filled with coloured fluid; the bottom of it being of glass, you will see the fluid displaced by my blowing, even with a slight force, into one end of the tube. If I now uncork the opening on the distal side of the trap (replacing the cork by a vent-tube), I can blow my hardest without displacing the fluid.

Now what influences are at work to force gas back through traps?

a. The expansive force caused by pouring water into a drain. Two bodies cannot occupy the same space at the same time. If the lower part of the drain be full, or its mouth closed by water in the sewer into which it empties, then the sudden pouring in of water will cause the confined air to burst its way back through the trap.

b. Storm water suddenly filling the sewers has the same action.

c. The expansive force of hot water entering and increasing the temperature and consequently the bulk of the air. If raised suddenly from 50° to 150° the result would be a pressure equal to nearly seven feet head of water.

d. Direct afflation through the sewer. The wind blowing up the sewers, e.g., a south wind in Toronto. Some engineers have proposed flap gates at the mouth. But don't have this,

let the fresh air blow up, but make vents for it to sweep through and purify the sewers.

e. Partial choking of the drain gives rise to confined air constantly increasing and expanding and being displaced. A vent allows the escape of all gas which would otherwise force the trap.

3. Again sewer gas may be admitted by the trap being emptied by syphoning, the water being syphoned out. If I add this tube to the distal end of the trap, it forms the long leg of a syphon, this portion of the trap being the short leg; being closed and a full stream poured through the trap, the water will syphon out of it, leaving the seal broken, as I have often proved by actual experiment with this trap. An opening at the arch of the syphon will, of course, prevent this.

I remember your once asking me, Mr. President, if a waste basin trap could be syphoned in this way, the pipe below being generally larger than the exit from the basin. Since that time I have seen at least two cases: one of a kitchen sink, which had to be remedied by inserting a vent tube; the other, a wash basin, which may be still experimented upon at the Grand Central Hotel.

4. A large body of water rushing full bore down a pipe into which a trapped tube empties, will suck the water out of the said trap. I now show you a vertical 4-inch pipe with a junction, into which I fit my glass trap. I have often sucked the water out of the trap by this apparatus.

The vent will, of course, prevent this.

5. Alterations may leave some pipe open or unsealed.

6. Disuse of trap for a long time will allow evaporation and emptying of trap, giving room for free passage backwards of gas.

7. Corrosion of pipes and traps, or bad workmanship in joints, will often allow escape of gas.

8. Absorption through contents of traps. Gas absorbed and given through. Forbes experimented with ammonia, and found it transmitted in about twenty minutes.

This may be obviated by having a second vent-tube, and these two will form a circula-

tion of air, preventing foul air from accumulating—stagnant—at the trap.

In a system of house drainage, one of these two tubes may be secured by running a 3 or 4-inch pipe from the sewer, just outside the house wall, up to the roof, clear of cornices and windows; whilst the other will be obtained by continuing the soil-pipe up through the roof. A difference in temperature in the pipes will cause the air to circulate through them. This latter pipe will save the traps opening into it from being forced by gas from the sewer and drain. The traps of the baths and lower closet—all traps in fact below the uppermost one—must be saved from suction by their own little vents. These minor vents may open into the extended soil-pipe above the highest trap.

In the diagram, pipes will also be seen arising from a point below the hopper of the closet, a little above the water in the trap. These pipes may serve a double purpose. By branches from the water closet tanks they may act as flushers to the water closet traps, and they may also ventilate the water closets. They may lead to the outer air, or the chimney flue of an isolated kitchen in constant use; but never into a bedroom chimney, or any other not used *constantly*, in the strictest sense of the word. This permission I would not grant in the case of any tubes which have direct connection with the drain; and yet I know this to have been done.

As for the trap shewn in dotted lines between the house wall and the street sewer, I would leave it out of this system, were the system to become generally adopted (as it should be by by-law); for a point away up thirty feet or so above our heads is surely the best place to discharge the gas from our sewers, and not at our feet. But if it were not general, then I would yield to a very pithy remark made by my friend, Dr. Joseph Workman, "not to ventilate the whole street on the house top of one" enterprising individual; although if I were the individual, and the street ventilator in front of my house, I think I would then be still worse off than by having it on the roof of my house.

I have made a large diagram, showing how some of the principles of drain ventilation have been nullified in the Asylum of one of the neigh-

boring States, by placing both the tubes in the same furnace shaft, thereby keeping the air in both at the same temperature, and hence stagnant; whilst a trap between the two makes the "assurance (of no circulation) doubly sure."

Before closing, let me enter a protest (in which I know you, Mr. President, will join,) against the "pan" closet—the closet in most common use. Every time the handle is raised, the "pan" discharges its contents into the "receiver," and displaces, in an upward gush, the foul air contained in it, doubly foul from the repeated coatings of fecal matter adhering to its wall as it is dropped into it from the pan.

There are good forms of patent closets; but the simple hopper, with a good swirl of water to keep its walls washed clear of feces whilst in use, and with an occasional flush, is quite as good as any, and better than many.

Its trap should be placed above the floor, so as not to leave a long tube between the bottom of the hopper and the surface of the water in the trap. This lessens to a minimum the surface for filth accumulation. The trap is also more accessible, if broken tumblers or other impediments should get into it.

No space should be left between the seat and top of hopper, for urine or other water to slop over. This often gives rise to unpleasant accumulation. If such space exist, it should be stuffed with papers, frequently changed.

In concluding, Mr. President and Gentlemen, I must say that I am aware that this paper is somewhat confused in arrangement. This has arisen from the fact of my having departed from my original intention, and having endeavoured to say something about the disposal of all decomposable material, in country as well as in town; by which departure I have brought together parts of my subject dealing with the "dry system" of removal, and parts dealing with the "wet," or "sewer" system.

For any such confusion that may exist, I apologize, and ask your indulgence.

Out of 144 candidates who presented themselves on the 21st of May for the Primary or Anatomical and Physiological Examination for the M.R.C.S. Eng., 69 failed to acquit themselves to the satisfaction of the examiners.



## ON THE TREATMENT OF ASTHMA.

BY G. L. MACKELCAN, M.D., HAMILTON.

(Read before the Ontario Medical Association, held at Toronto, on June 1st, 1881.)

MR. PRESIDENT AND GENTLEMEN,—This paper is written with the object of showing the beneficial effect of chloral hydrate in the treatment of asthma. Asthma being a disease marked always by a certain amount of periodicity in the attacks of dyspnoea, and being divided into the three varieties of cardiac, dyspeptic, and bronchitic, the latter form being the most common.

Taking for a theoretical basis the idea that the attacks originate from some peripheral disturbance of some branch or branches of the pneumogastric nerve, which is communicated to the nerve centre, and that the attack could be arrested by paralyzing the nerve centre, as it were, the paroxysm could be cut short, and if cut short, the habit would ultimately be broken up, I thought that chloral hydrate would have the desired effect. The first case that came under treatment was an old standing one of thirty years, of the cardiac variety. This old gentleman had been subject in the first years of the disease to the violent periodical paroxysms, but latterly it had become almost continuous, so much so indeed, that he had not lain down in bed for some months. The remedy was given in 3i doses at first, as I presume, it was by most of us when it came into use. The dose was then gradually decreased until five grains, three times a day, were taken. The effect of the treatment was such, that in a very short time, he was greatly relieved of his asthma, and at the end of six months he was entirely free from it. He lived for ten years afterwards and never was troubled with it again, although living in the same neighbourhood. He told me that he gave my prescription to others suffering from the same disease in his locality, and that it entirely relieved them.

The next cases treated were four members of the same family. I had treated the father for some time on the old plan that I had been accustomed to, but with only temporary relief. As soon as he began the new treatment with chloral hydrate he began to improve, and after three months he had no return of the disease.

Sometime afterwards the mother came for treatment for the same disease and in her case I believe she never had a subsequent attack. About two years after, the son and daughter came to be treated for the disease and were well enough to discontinue the remedy, one in three and the other in six months.

The next case was that of a lady whom I had treated for asthma for twelve years with very unsatisfactory results. On commencing the treatment by the then new remedy, she obtained six or eight hours sleep, during which the breathing was tranquil; but as soon as she waked, the difficulty returned in full force. She continued the treatment for some years with the above-named effects, but ultimately died from the disease.

The next case was that of a middle-aged woman whose asthma was evidently due to dyspepsia. She was always relieved at once of the attack, but some error in diet would bring on an attack at any time; as I lost sight of her I presume she was not cured.

Next comes the case of an elderly lady whom I saw in consultation. The same treatment relieved her entirely from the spasmodic attacks, but she never regained her normal breathing on account of extensive emphysema. In this case and subsequently the dose of the medicine was reduced to one scruple or 3ss, and repeated if necessary.

Then comes the case of a young man, aged twenty-two, with his first attack which was fully established before treatment was commenced. In his next attack about three months after, it was broken up at once and he never had another, and that is two years ago.

Still another young man of twenty-three who had suffered from chronic bronchitis for a year, had a violent attack of asthma, which gave way to the treatment at once, and for a year he was free from both bronchitis and asthma. At the expiration of the year he had another paroxysm which was soon broken up and he has not had another since.

Again, with regard to the disease in young children, when the diagnosis is made out, which is not always easy, the effect of the treatment has been very remarkable. Four cases from three to ten years of age, treated by from six

to twelve grains have been completely relieved from any further attacks.

Asthma having been considered quite incurable from my own former experience and that of others, and all the known remedies appearing to give only partial and temporary relief, I was pleased at finding a majority of cases (11 in 14) cured, and the others relieved to a certain extent.

DISCUSSION.—Dr. Geo. Wright, Toronto, introduced his remarks by saying that he did not know whether or not the experience of the members of the Association, with reference to the use of chloral, and the precautions necessary in its administration, was the same as his own; but he had become satisfied, from what he had seen in this city himself, and what had occurred in the hands of other practitioners, that the drug was a very formidable one, and required extreme caution in its use. There might be some forms of asthma in which it would be useful, but in long-standing cases, where there was invariably some form of impaired heart action, he thought it very questionable practice to give chloral in doses as large as were recommended by the reader of the paper. He then referred to several cases in the city, in which comparatively small doses had produced fatal consequences, and expressed his belief that more than 15 grain doses were rarely safe, and said that, in many cases, he would not venture to give even so much. In reply to a question by Dr. Workman, as to the danger of acquiring the chloral habit he said he had no experience.

Dr. Oldright, Toronto, said that we had not been so heroic in Toronto as they had been in Hamilton, as we only gave 20 to 30 grains at first, so far as his observation had extended. He had found benefit from Belladonna, Ether, and Ammonia, and possibly also from Grindelia Robusta, in asthma.

Dr. Madill, Alliston, thought that the remedy was a dangerous one, owing to the uncertainty of the strength of different preparations. He himself had been almost a victim to that uncertainty, and in country practice he would almost discard the use of the drug. He recognized its utility and power in certain cases, but thought that others would not meet with the same success that Dr. MacKelcan had done.

He himself had found no difficulty in leaving off the drug.

Dr. Bowlby, Berlin, had followed this treatment with satisfaction and success.

Dr. Geikie, Toronto, approved of the treatment in certain cases. He had had some experience of the formation of the chloral habit, but thought the danger was not great.

Dr. Sloan, Blyth, remarked that a distinction ought to be made as to cases which were complicated with valvular insufficiency. Chloral was not likely to prove curative in those cases, although of great value as a palliative. For himself, there was no other drug in which he had the same confidence in asthmatic cases. As respects the chloral habit, he had seen cases using it one, two, and three years, and had no difficulty in discontinuing its use. With reference to Dr. Madill's remarks he would say, that he would as soon discontinue morphia, because some untoward results had followed its use, and that the physician who discards chloral, neglects a valuable remedy, for which in some clinical conditions it will be difficult to find a substitute.

#### A CASE OF RECURRENT HERPES PROGENITALIS.

BY J. E. GRAHAM, M.D.,

Lecturer on Dermatology and Clinical Medicine, Toronto School of Medicine.

The following case came under my observation about a year ago, having been sent to me by Dr. Dunfield, of Petrolia, to whom I am partly indebted for the notes given:—

A. B., æt. 26, came to my office for consultation April 27th, 1880. Patient is a strong, healthy-looking man. He has always enjoyed good health with the exception of the local trouble about to be described. He had gonorrhœa, for the first time, about ten years ago. He has had repeated attacks of that disease since. There is no evidence of his ever having had any other form of venereal disease, except perhaps chancroid. About nine years ago he noticed a small ulcer behind the glans penis, which did not heal up for some weeks. The ulcer returned singly two or three times. Three or four of them then made their appearance, healed up, and after a few weeks re-appeared.

The number of vesicles increased so that during the last few years eight, ten, or a dozen



appeared each time. The history of a single outbreak is as follows:—He notices an itching and burning of the skin about the glans near the frenum, on examination he finds a group of little vesicles, sunken as it were, in the integument so that they appear like pearls imbedded in the skin, with their upper surfaces very slightly raised. In a day or two the vesicles rupture leaving round, sharply cut ulcers. The ulcers regularly become covered by scabs and heal up, sometimes rapidly, sometimes slowly. The part remains healed for a variable time, from one to six or seven weeks and then there is a return of the vesicles, as already described.

Patient has received constitutional and local treatment, principally of an anti-syphilitic character. Neither the constitutional nor local treatment given appear to have had any effect.

A curious feature about the case was, that he never suffered from the herpes when an attack of gonorrhœa was present. I advised pot. bromid., and a soothing external treatment.

About two months after I saw the patient, I received a letter from Dr. Dunfield, stating that my line of treatment was carried out without any effect whatever. Patient has passed from observation, having gone to Ceylon.

*Remarks.*—This is the second case of recurrent herpes progenitalis which I have met with. The first case had lasted about two years before I saw it. No treatment was of any avail. The last I heard of the patient was that there was danger of insanity, the result of constant mental worry about his almost incurable condition.

M. Doyon, of Lyons, in an exhaustive article on the subject of recurrent herpes progenitalis, says, "Recurrent herpes is often mistaken for chancroid. It is the fourth in order of frequency amongst venereal affections, gonorrhœa occupying the first place, then chancroid, and then syphilis. It uniformly follows some primary venereal affection, dies away and then re-appears for many years together, about every two months." He considers that the origin of the affection can be traced to a primary or inherited dartsous diathesis.

Dr. Greenough, of Boston, in an excellent paper read before the American Dermatological Association on "Herpes Progenitalis," refers to this recurrent variety. The subject does not seem to have received that attention in medical literature which it deserves. As to the therapeutics, the remedy which will cure or even limit its duration has yet to be discovered.

## THE TREATMENT OF GONORRHOEA.

BY JOHN FERGUSON, B.A., M.B., L.F.P.S., GLASGOW.

Few diseases have claimed more attention, and been subjected to a more varied system of treatment than gonorrhœa. In the face of all the plans, which have been, or are in vogue for its treatment, I shall venture to suggest one, which has yielded more satisfactory results than any other I am acquainted with. Its application is easy and free from pain, and is equally well suited to all the stages of the complaint.

The local application of a medicated substance, or fluid, is a favourite mode of treating local disorders; and, even where the local disease is the result of some constitutional taint, topical agents are often among our most useful means of affording relief. It is with the view of effecting the local treatment of gonorrhœa in as short a time, and with as little suffering and bad after effects as possible, that I propose the following:

About six feet of quarter-inch soft rubber tubing is attached at one end to a small lead pipe, which admits of being bent so as to hang over the edge of a bowl, or other suitable vessel, and dip down to the bottom of any fluid it may contain. To the other end of the rubber tube is attached a soft rubber catheter, No. 6, in the end of which are made about eight small openings instead of one large eye. The patient is directed to sit near the edge of his chair, so as to leave the urethra and perineum in a relaxed condition. In the bowl is put a weak solution of Condyl's fluid, and then placed on an elevated stand as a shelf or sideboard. The temperature should be that of the body. The syphon action of tube and catheter is established, and then compressed by the finger and thumb. The catheter, after being anointed with vaseline, which suits better than any other lubricant, is gently passed up the urethra to near the prostate gland. The fluid is now allowed to flow. It escapes through the small openings in the end of the catheter, and washes out the urethra from behind forwards, the soft catheter slightly dilating the canal, and yet not obstructing the flow in any way. The medicated fluid must in this way come into even contact with every part of the mucous membrane; and, whilst accomplishing the object of thorough local ap-

plication, also removes all irritating discharges. This can be done twice daily, and is attended with no other than a grateful sensation to the patient. The curative results are equally good—theseverest and most protracted cases yielding in a comparatively few days. The patient can use it himself.

[This is essentially the proceedure of Mr. Reginald Harrison, of Liverpool, and is strongly recommended by him. Dr. W. Thornton Parker, of Plymouth, Mass., has brought before the profession for this purpose a soft rubber nozzle,  $2\frac{1}{2}$  inches long, with eyes directed backwards; but except in the very early stages, this length appears to us insufficient.—ED.]

### A BRIEF REPORT OF A CASE OF ABSCESS OF THE MASTOID CELLS FROM THE USE OF THE NASAL DOUCHE.

BY A. M. ROSEBRUGH, M.D.,  
Surgeon to the Toronto Eye and Ear Dispensary.  
(Read before the Ontario Medical Association.)

(This patient was introduced, and an opening in the left mastoid bone was seen to communicate with the mastoid cells. Inflations of the eustachian tube caused a suppurative discharge to make its appearance at the opening.)

The history of this case is briefly as follows: Edward K., aged 19, has had chronic nasopharyngeal catarrh for four years. Two years ago he was advised by his physician to use the nasal douche. Since then he has used it occasionally—using about a teaspoonful of table salt to a pint of warm water. On the 21st of May last, while using the douche, he felt the solution enter his left ear. On the 22nd he felt very weak, but he had no pain. On the 23rd pain commenced in the left ear, and on the 25th spontaneous perforation of the drum membrane occurred, with copious discharge of a dark sticky fluid from the middle ear. The pain continued, however, notwithstanding a copious discharge, and extended over that side of the head, and which was not relieved by leeching and hot fomentations. There was also vertigo and pain down the back and lower limbs. On the 28th there was some œdema of the lining of the external auditory canal, and on the 30th, slight tenderness over the mastoid

bone. An operation was then decided upon, and on the evening of the same day, or nine days after the accident, he was placed under chloroform, a free vertical incision made about half-an-inch behind the auditory canal, and an opening about  $\frac{1}{2}$  of an inch in diameter was made through the bone into the antrum by means of a drill. This gave exit to a large quantity of purulent fluid, and gave the patient immediate relief. This is the tenth day after the operation and the case, as you see, is now doing well.

The nasal douche, as you are aware, is very extensively used in the treatment of nasal catarrh, and I introduce this case for the purpose of calling attention to the need of greater care in its use. It is true that very few cases of abscess of the mastoid cells from the use of the nasal douche have been reported, but cases of suppurative inflammation of the middle ear from this cause are not uncommon. When a fluid under pressure enters one nostril, the soft palate is elevated by reflex action, and if there is no obstruction the fluid passes out of the opposite nostril. If the pressure is slight, there is very little danger to be apprehended; but if the hydrostatic pressure is considerable, as is the case when the reservoir containing the solution is higher than the head, and if there is also some obstruction to the free exit of the fluid there is great danger of the solution passing up the eustachian tube into the, and perhaps also, as in this case, through the antrum into the mastoid cells.

Let me emphasize the precaution, that when the nasal douche is used, first, the forehead should not be inclined forward; second, the bottom of the reservoir should not be higher than the eyebrows; third, the orifice of the nose-piece should not be large, and fourth, special care should be taken to see that no obstruction exists in either nostril.

#### ERRATA.

In the paper by Dr. R. L. MacDonnell, in our last issue, there are some typographical errors: Page 168—For *Zen Ryne*, read *Ten Ryne*; for *Acupuncturax*, read *Acupunctura*, &c.; for *Walles*, read *Tralles*. Page 69—For *preventative*, read *preventive*; for *gout*, read *gleet*; for *Sculletus*, read *Scultetus*. Page 171—For *ingenius*, read *ingenious*.



## A CASE OF MICROCEPHALY.

BY C. K. CLARKE, M.D.,

*Ap'um for the Insane, Hamilton.*

J. W. T—, æt. 41, height 4 ft. 11½ inches, weight 103½ lbs.

Measurement of head :—Greatest circumference, 18½ inches ; right side of head, 9 inches ; left side, 9½ inches.

Inter-mastoid arches :—Anterior arch over supra-orbital ridges, 12 inches ; frontal arch over frontal eminences, 12 inches ; middle arch nearly over coronal suture, 11 inches ; superior arch nearly over vertex, 10¾ inches ; posterior arch over occipital protuberance, 7¾ inches.

Diameters :—A base line from one mastoid to the other, 4½ inches ; greatest transverse, 4½ inches ; greatest antero-posterior, 5¾ inches.

Distance from root of nose to occipital protuberance, 11 inches.

The idiot is very clean and careful in his habits, Is able to make himself understood, although his knowledge of the English language is very limited, has more intelligence than you would expect from the small size of head. It is probable that some attempts have been made to educate him, as he frequently goes over a "jumble" which sounds something like one of the arithmetical tables.

## Correspondence.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

## TEACHING OF ANATOMY.

Sir,—The recent examinations of the Ontario Medical Council, where the Assyrian seems to have come down like a wolf on the fold, have proved a severe lesson for those teachers who have sent up students badly prepared for that most important trial, the examination in general and in surgical anatomy. I hope that they will take it to heart, and that for the future we shall hear more of dissecting and dissecting-room demonstrations, and less of lectures and of written description work.

Mr. Editor, my experiences are by no means peculiar and every young Canadian graduate who has been abroad will, I think, agree with me when I say that when I was in England, so utterly ignorant was I of anatomy, that I was actually ashamed to let it be known that I was

a graduate, a qualified man in my own country.

In the spring of 187— I graduated in medicine at a first-class Canadian University and was also one of the prize-men in my year. In the previous year at the Primary Examination my paper on Anatomy took full marks, and few could recite the intricate meanderings of the fifth nerve, with greater accuracy than the writer. Grim rumours, it is true, had reached my ears, as to the severity of Anatomy Examinations abroad, but I thought myself above listening to such childish prattle. Had I not sat on a hard bench, often asleep, it is true, often day-dreaming, while three hundred hours were spent in anatomical recitations, while a lecturer repeated to me the very text of Wilson or Gray, and tried to teach me things which a good demonstrator could have taught me in a few minutes. All these things had been done, and I thought it would have been very foolish of me to get into a fright about cock and bull stories of dissections. Wonderful tales I had been told, too, of my fellow-countrymen. Canadians always got through, to the envious disgust of the students of the Mother Country.

I landed then at a London hospital, hungry and thirsty for knowledge. I met an old friend there, who after a little conversation volunteered to see how much anatomy I knew. He had just passed his first college. "You had better take a grinder," he said, "and go up in three months." I did so. In a few days I found myself in a grinder's class. Here were three Canadian graduates like myself, of these, two were honour-men of their college. Some four or five members of the class were English "chronics" of the worst sort. A "chronic" is a student who has repeatedly failed, either from stupidity, idleness, or both combined, in getting his "first or second college." These men had been up three or four times already, and had been advised to "try it next shot for, as the grinder said, they would be as well up then as it was possible for them ever to be, even if they studied one hundred years. The remainder of the class were boys fresh from school, whose juvenile prattle at times made me fancy that it was *pons asinorum* no the *pons Varolii* we had under our consideration

We worked very hard, until at the end of three months, and weary ones they were, we were thought fit to go up. Yes! we, graduates of different Canadian Universities, after three months' hard work were thought fit to go up for an examination, one whose standard is the the lowest in England, the diploma gained at which is of the least value amongst all the surgical distinctions to be won in that country. I hope in the future to see no more Canadian M.R.C.S.'s and L.S.A.'s or Edinburgh "double qual." men; but that our young men will return to practice with something worth having, Fellows of the College of Surgeons or Members of the College of Physicians.

Students in Canada are over-lectured and under-taught.

Now in Anatomy the professor or lecturer is looked upon as being responsible for the teaching in that branch. Lecturers on Anatomy should be abolished universally. The demonstrator should have control of the entire department. There should be no lectures in anatomy, but occasionally, say twice a week, the senior demonstrator should take up particular regions in turn and give demonstrations upon them. For a school with more than one hundred students there should be at least four junior or assistant demonstrators. Their hours of attendance should be so arranged that the room should never be left without a teacher in charge. Their duties should be to constantly watch, teach, and examine the students in the course of their dissections. A senior demonstrator should have rank as a professor, and he should be well paid—well enough to prevent his allowing the demands of private practice taking him away from his work. At the regular hours laid down by the Faculty for dissecting, the senior demonstrator and all his assistants, should be present at the same time.

The junior appointments should be honorary or they might have a very slight salary attached to them. They would serve as a training-school for other chairs.

Anatomy should be taught by regions entirely. A student should learn the arm, the leg, the abdomen, &c., and not take up all the nerves at once, all the muscles, &c. Why, it's like earning the geography of Europe by taking all

the rivers at once, all the towns, or all the mountains. The books in a student's hands should be Heath's Anatomy, or Ellis', or Holdens', the osteology of Holden, and his work on Landmarks. Forever banish Gray, Wilson, &c.

At the end of the session, there should be an examination for first, second, and third year students. Its *sine quâ non*, should be an oral, practical examination on the dissected subject itself, followed by a written paper with questions of a good practical nature, such as "The dissection, to expose such and such an artery;" questions calling out a candidate's knowledge gained by dissection, not that which he has learnt by heart the night before. Such as this which I select at random from a number in my possession, "enumerate the muscles attached to the os innominatum."

Anatomy examinations are different from those in any other subject. All mistakes, for example in Surgical Anatomy are not the same mistakes. There are trivial ones and fatal ones. A student who after having been given plenty of time cannot tell, for instance, what the external abdominal ring is, when it is pointed out to him, or one who cannot point out the valves of an opened heart, should be plucked, no matter how well he has answered in everything else.

The Ontario Board should appoint several examiners in anatomy, and arrange that no student should be examined by his own teacher. Moreover, while one examiner asks the questions the others should mark. Altogether as things are at present the lot of an examiner of the Ontario Medical Council "is not a happy one." When he conscientiously does his duty, as I have not a doubt Dr. Sullivan did, he must be prepared for slanders and calumnies of the vilest sort. And I undertake to say that any real anatomist, and by that term I mean a practical anatomist, not a book anatomist would act, in fact could act in no other way, than did Dr. Sullivan, that is to say, if he had the manly courage to do it.

With many apologies for trespassing to such an extent upon your columns,

I remain, Sir, your obedient servant,

A MERE ANATOMY.



THE CANADIAN  
**Journal of Medical Science,**

A Monthly Journal of Medical Science, Criticism,  
 and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, JULY, 1881.

ONTARIO MEDICAL COUNCIL.

The recent Session of the Council was upon the whole a very satisfactory one. Dr. Bergin was, as a matter of course, elected President, and the able manner in which he performed his duties as chairman assisted much in carrying on both the ordinary and the rather extraordinary business of the meeting. Dr. Bray, of Chatham, a representative from the west, was elected Vice-President.

The burning question of the day was soon introduced by the presentation of the rejected candidates' petition by Dr. Bray, and a long debate followed, which, all things considered, was exceedingly creditable to the Council. While taking exception to some minor points, we recognize that many of the speeches were able, eloquent, and argumentative—especially those of Drs. Bergin, MacDonald, Lavell, McCammon, Burritt and Williams.

They appeared to realize that the honour not only of the examiners, but also of the Council and whole Profession, was called in question by the ill-advised petition, and in connection therewith, the abusive and foolish letters which had been published in the daily newspapers of Toronto, and they were determined to uphold it. The unfortunate action of the plucked men had created in the minds of some a feeling of resentment, which made them rather harsh. The petitioners, most of whom were present by the courtesy of the Council, must have felt a bitter disappointment when they found that not a single member of the Council had a word to say in defence of their conduct, although, as all know, they had

previously been strongly encouraged in their course of petitioning and letter-writing. Under the circumstances they thought it better to withdraw their petition on Wednesday evening, and throw themselves on the mercy of the Council. Here again they were disappointed, as, when the subject was finally disposed of on Friday evening, the members of the Council refused to grant them any grace whatever. They seemed to be reserving all their sympathy for the case of Dr. Jno. B. Hall, which came up for consideration a few minutes after the rejected were disposed of, and was treated with distinguished marks of favour. It looked as if they were trying to atone for their harshness in the first case by exceptional good nature in the second. We direct attention to the vote quoted in the report of the proceedings.

A good deal of work was done by the various Committees, and we must refer especially to the labours of the Education committee. The result is, that many matters in connection with the examinations, which were before in an unsatisfactory position have been adjusted. The intermediate examination with Latin; *i.e.*, including the compulsory subjects and Latin among the optional, is to be, accepted for matriculation. In the professional examinations, a pass and honour list will be given, and a definite standard has been fixed for both. The required percentage will be 45 for pass, and 75 for honours, in the following subjects: Surgery, Medicine, Pathology, Midwifery, Descriptive Anatomy, Physiology and Materia Medica; 40 pass, and 70 honours in Medical Jurisprudence; 33 pass, and 66 honours in Sanitary Science and Surgical Anatomy; 30 pass, and 50 honours in Chemistry and Toxicology; 25 and 50 in Botany. Arrangements have also been made to have the final partly oral and partly written.

The motion of Dr. Day, that a committee be appointed to endeavour to procure certain changes in the Medical Act, was carried unanimously. The effects of the Changes suggested would be to do away with the representation of Ottawa and Albert Universities and prevent the representation of any University which does not grant degrees in medicine.

## THE NEGLECT OF GYNÆCOLOGY AT THE TORONTO GENERAL HOSPITAL.

We question the wisdom of the course pursued by the Trustees of this Institution in making the appointments of its staff annually, as we think it impairs very much its usefulness. We believe the members of the staff would feel more interest in their work and we know their usefulness would be much increased by a certainty of a longer term of office.

The Hospital was established to relieve the sick and afflicted, but its benefits are by no means confined to those who seek relief within its walls. In fact if properly conducted it may be a blessing to a very wide constituency. As an educator of the men who go out every year to care for the health of the people, it is capable of extending its benign influence to every hamlet and town in the Dominion, and just in proportion as the hospital fails to provide these young men with every facility for the acquisition of professional knowledge, does it fail in its high mission.

Hence we regret exceedingly that while the Trustees were rearranging the appointments for the coming year, and went so far as to appoint specialists in midwifery, they did not see their way clear to the establishment of the department of gynæcology when it could have been done without any additional expense. About three hundred young men seek their medical education in Toronto every year and the majority of these take out hospital tickets at some period of their probation and are entitled to all the advantages the hospital is capable of affording, and yet the hospital authorities provide no facilities for their practical instruction in one of the most important departments of the whole curriculum.

We know that while an abundance of material presents at the hospital for the illustration of the subject, yet it is not utilized for the benefit of the medical classes and chiefly for the reason that the general practitioner cannot spare the requisite time.

Some of the Trustees have expressed a desire for the establishment of such a department and yet because one or two members of the staff wish to retain their right to such cases (a privi-

lege which we think need not be interfered with), the matter is postponed, the hospital fails to perform its duty, the young men are sent out imperfectly prepared to grapple with a class of diseases which constitutes a very large proportion of the sufferings of humanity, or they are driven to seek elsewhere that instruction which it is our duty to provide for them at home, and which could be readily furnished in an institution so largely supported by the people's money.

We know that many members of the staff would gladly turn over these cases to the specialists as they require so much time for their proper elucidation, but the dog in the manger spirit of one or two, prevents the arrangement being carried out. It is a matter of frequent occurrence for young men in remote parts of the country to write to us for instructions in regard to the simplest operations and examinations of gynæcology, as during the whole four years of their study, many of them have never seen a speculum, or a sound used, or a pessary introduced. A short time ago a gentleman wrote us that he would come a hundred miles if we would notify him when he could see us introduce a uterine sound.

We, therefore, think it a great pity that the Trustees should allow the selfishness or jealousy of one or two men to prevent them doing what they feel would be to the advantage of the hospital, and what we know would be simply an act of justice to the large class of medical students who pay for instruction at the hospital which they do not get, and which would be of vast benefit to the community at large, through the young men thus more perfectly instructed.

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## THE CASE OF DR. JOHN B. HALL.

The profession of Ontario would probably like to hear some reasons for the extraordinary action of the Council with reference to this case. The doctor referred to is a homœopathic physician, practising in this city as assistant to his father, Dr. John Hall, but has no license. He has, we understand, a degree obtained nearly 20 years ago from some Homœopathic College in the United States, and he now wishes to be registered by the Council. In



the report of the Registration Committee we find the following :

Dr. Bray moved that Dr. Hall be examined by the Homœopathic members of the Council, as an inexpensive method of testing his attainments, as this is a special case, and if found qualified that his name be put on the Register.

Amendment moved by Dr. H. H. Wright, seconded by Dr. Lavell :—

That the Council go back into Committee of the Whole to amend the report by inserting the following words :

That Dr. John B. Hall shall be admitted to Registration in the usual way—by undergoing the usual examinations and in the usual way. *Lost.*

YEAS—Drs. Burns, Lavell, Williams, and Wright.

NAYS—Drs. Bray, Burritt, Cranston, Douglas, Edwards, Henderson, Husband, Logan, Morden, McCammon, McCargow.

As the Council is at present constituted, a Homœopathist is entitled to the same consideration as a member (or a would-be member) of the Regular Profession, and not any more. What are the special reasons which induced a large majority of both Homœopaths and Regulars in the Council to grant such an unusual concession to this gentleman? The resolution speaks of it as “an inexpensive method.” What does this mean? Why is it inexpensive? Has some Homœopathic friend agreed to examine him for little or nothing? If a *cheap* method has been found, will the members who voted for the resolution maintain that such a consideration justifies in the slightest degree such an irregularity? What necessity was there for any hasty action? This gentleman has been living in Canada for a number of years and knows our laws. Why has he not passed in the regular way?

We will leave the question to the consideration of the Profession, while we simply express our wonder that only four men among those present felt it their duty to vote for his “admission in the usual way.” A few such irregularities as this sanctioned, sometimes from pure good nature, sometimes from pure carelessness, have done a great deal to make the Council unpopular with a certain section of the Profession in Ontario.

## CONVOCATION OF TORONTO UNIVERSITY.

At the Convocation on Wednesday, June 8th, the following received the degree of M.D. :

Spencer, B.; Gardiner, T. H.; Murray, S. S.; Burton, W. H.

### DEGREE OF M.B.

Aikins, H. W.; Aikins, W. H.; Bingham, G. S.; Bosanko, S. A.; Burt, J. C.; Catton, J. M.; Cotton, R.; Elliott, H. R.; Edmondson, W. C.; Gunn, W.; Howitt, F. W.; Jones, A. C.; Machell, A. G.; McBride, J.; McCracken, C. L.; Montgomery, W. A. D.; Nicholson, M. A.; Sweetnam, L. W.; Tracey, W. J.; Wallace, M., from the Toronto School of Medicine.

Beck, G. S.; Bentley, L.; Ferguson, A. H.; Kerr, H. K.; May, P.; Mearns, W. A.; Meldrum, P. G.; McTavish, D. A.; Vandervort, E. D.; Witherspoon, W. L., from the Trinity Medical School.

The following passed the Primary :

Coulter, R.; Cuthbertson, W.; Frost, R. S.; Freely, A. I.; Jackson, H. P.; Lepper, W. J.; Nasmith, A. D.; Walmsley, P. C.; Wilmot, J. W., from Toronto School.

Harrison, B. D.; Ray, J. W.; Shore, J. E., from Trinity School.

*Third Year.*—Knill, E. J.; McMahon, T. F.; Fletcher, W.; Cleland, G. S.; Montgomery, D. W.; Duncan, J. T.; Bell, J. F.; Eastwood, W. F.; Fisher, R. W.; Lafferty, J.; Kent, F. D.; Johnson, W. H., from Toronto School.

Panton, A. C.; Hanbridge, W.; Ferrier, J.; Wallace, R. R.; Woolverton, S. S.; McMurrich, J. R.; Milroy, T. N., from Trinity School.

### MEDICINE.

Class I.—Panton.

Class II.—1, Knill; 2, McMahon; 3, Hanbridge; 4, Fletcher; 5, Ferrier; 6, Cleland; 7, Wallace; 8, Montgomery; 9, Duncan; 10, Bell; 11, Eastwood; 12, Fisher.

Class III.—1, Lafferty; 2, Woolverton; 3, McMurrich; 4, Milroy; 5, Kent; 6, Johnson.

### CLINICAL MEDICINE.

Class II.—1, Milroy; 2, McMurrich; 3, Lafferty; 4, Duncan; 5, Cleland; 6, Wallace; 7, Panton.

Class III.—1, Fisher; 2, Montgomery; 3,

Knill; 4, Ferrier; 5, Bell; 6, Fletcher; 7, Johnson; 8, McMahon; 9, Eastwood; 10, Kent; 11, Hanbridge; 12, Woolverton.

#### SURGERY.

Class I.—1, Duncan; 2, Wallace; 3, Fletcher; 4, McMahon; 5, Hanbridge; 6, Panton; 7, Eastwood.

Class II.—1, Ferrier; 2, Montgomery; 3, Bell; 4, Fisher; 5, Knill; 6, Johnson; 7, Lafferty; 8, Cleland.

Class III.—1, McMurrich; 2, Milroy; 3, Woolverton; 4, Kent.

#### CLINICAL SURGERY.

Class I.—Wallace.

Class II.—1, Panton; 2, Ferrier; 3, Lafferty; 4, McMurrich; 5, Cleland; 6, Duncan; 7, Montgomery; 8, McMahon; 9, Eastwood; 10, Hanbridge.

Class III.—1, Fisher; 2, Knill; 3, Johnson; 4, Milroy; 5, Fletcher; 6, Bell; 7, Kent; 8, Woolverton.

#### SURGICAL ANATOMY.

Class I.—1, Wallace; 2, Bell; 3, Duncan.

Class II.—1, Fletcher; 2, McMahon; 3, Cleland; 4, Panton; 5, Johnson; 6, Ferrier; 7, Montgomery; 8, Eastwood; 9, Hanbridge; 10, Fisher; 11, Lafferty; 12, Knill.

Class III.—1, McMurrich; 2, Woolverton; 3, Milroy; 4, Kent.

#### OBSTETRICS.

Class I.—1, Fletcher; 2, Wallace; 3, Duncan; 4, Ferrier; 5, McMahon; 6, Bell; 7, Fisher; 8, Panton; 9, Knill; 10, Hanbridge.

Class II.—1, Lafferty; 2, Cleland; 3, Johnson; 4, Eastwood; 5, Montgomery.

Class III.—1, Milroy; 2, Woolverton; 3, McMurrich; 4, Kent.

#### PATHOLOGY.

Class I.—1, Duncan; 2, Wallace; 3, Panton; 4, McMahon.

Class II.—1, Knill; 2, Fletcher; 3, Ferrier.

Class III.—1, Eastwood; 2, Lafferty; 3, Woolverton; 4, Hanbridge; 5, McMurrich; 6, Montgomery; 7, Milroy; 8, Kent; 9, Bell; 10, Johnson; 11, Fisher; 12, Cleland.

*Second Year.*—All from Toronto School.

#### ANATOMY.

Class I.—Robinson, W. J.

Class II.—1, Doelsen, F. J.; 2, Meldrum, J. A.

Class III.—1, Clerke, H. S.; 2, Fletcher, W.; 3, Hansler, J. E.

#### PHYSIOLOGY.

Class I.—1, Doelsen; 2, Robinson.

Class III.—1, Fletcher; 2, Meldrum; 3, Hansler; 4, Clerke.

#### MATERIA MEDICA AND THERAPEUTICS.

Class I.—1, Robinson.

Class II.—1, Doelsen; 2, Fletcher; 3, Meldrum.

Class III.—1, Hansler; 2, Clerke.

#### CHEMISTRY, ORGANIC, AND PHYSIOLOGICAL.

Class I.—1, Doelsen; 2, Robinson; 3, Clerke.

Class II.—1, Hansler; 2, Meldrum.

Class III.—Organic only—1, Fletcher.

#### HISTOLOGY.

Class I.—1, Doelsen; 2, Robinson.

Class II.—1, Clerke; 2, Fletcher.

Class III.—1, Meldrum; 2, Hansler.

*First Year.*—McKenzie, A. F.; Spence, S.; Clerke, J. W.; Johnson, J. L.; Bray, J.; Richardson, W. A.; Draper, J. S.; Jacques, W. P., from the Toronto School.

Meikle, T. D.; Stewart, R. L.; Thompson, A. S., from Trinity School.

#### ANATOMY.

Class I.—1, Meikle; 2, Mackenzie; 3, Spence; 4, Clerk.

Class II.—1, Johnston; 2, Bray.

Class III.—1, Richardson; 2, Draper; 3, Jacques; 4, Stewart; 5, Thompson.

#### CHEMISTRY.

Class I.—1, Clerke; 2, Spence; 3, Johnston.

Class II.—1, Mackenzie; 2, Meikle.

Class III.—1, Bray; 2, Stewart; 3, Jacques; 4, Richardson; 5, Thompson; 6, Draper.

#### BIOLOGY.

Class II.—1, Meikle; 2, Johnston; 3, Spence; 4, Clerke.

Class III.—1, Stewart; 2, Thompson; 3, Mackenzie; 4, Draper; 5, Jacques; 6, Richardson; 7, Bray.

#### MEDALS AND SCHOLARSHIPS.

Gold Medal—Duncan, J. H.; Toronto School of Medicine.

Starr Gold Medal—Duncan, J. H., Toronto School.



*Third Year.*—1st Scholarship, Wallace, R. R., Trinity School; 2nd, Duncan, J. T., Toronto School.

*Second Year.*—1st Scholarship, Robinson, Toronto School; 2nd, Doelsen, Toronto School.

*First Year.*—1st Scholarship, Spence; Toronto School; 2nd, Clerke, Toronto School.

First Scholarship, \$120; 2nd, \$80.

### THE LATE REJECTED.

We must protest against some of the remarks by certain members of the Council concerning the rejected candidates. The President, in his able speech on the notorious, if not celebrated, "Students' Petition," made a severe attack upon all who had signed this petition, and ascribed their position to their "gross ignorance," arising from "thorough idleness." Dr. McCammon went so far as to insinuate that their rejection was due to their "waste of time in saloons and theatres." These gentlemen, as members of the Council, should have remembered that they were called upon to act in a judicial capacity, and not as advocates for a suspected criminal, where they might obtain some advantage for the defendant by abusing the plaintiffs. These attacks were made in the presence of the rejected candidates, who, of course, had no chance to reply, and, under the circumstances, the language alluded to was neither just, manly, nor dignified, and was certainly not calculated to add any strength to Dr. Sullivan's position. While we have always disapproved of the conduct of the petitioners, we must do them simple justice, and say from positive knowledge, that many of the rejected were for years among the most earnest, faithful, and industrious students that we have had in Toronto during our recollection. Unfortunately, some of the best, with high aggregate marks, were plucked, while inferior men were passed, with a much smaller aggregate.

The case was, therefore, eminently an exceptional one, and we feel very sorry that the members of the Council were unable to grant them the favour of a supplemental examination. We must acknowledge that there were grave difficulties involved in such a course; but we adhere to the opinion expressed last month, that these difficulties might have been overcome.

### DR. SULLIVAN.

It looked at one time as if Dr. Sullivan was going to be put on trial. Such an action, even though that gentleman himself requested it, would have been the grossest injustice, because a trial implies at least some suspicion of guilt. It would have been a disgrace to the Council, and to the profession represented by the Council, if one of the most able, conscientious, and honourable practitioners in this country had been subjected to the indignity of a trial for a contemptible and criminal act, with members of the Council as a jury, and three or four or more rejected candidates as his accusers, without any shadow of positive proof to bring forward in support of their charges. Although in this controversy there has been much that is unpleasant to Dr. Sullivan, he may well feel proud of the fact that without exception those who have had the best opportunities of knowing him consider him in all respects above suspicion, and no single member of the Council had the hardihood to breathe a word to the contrary. As a mark of their confidence in him they have again appointed him examiner in descriptive anatomy. We are glad the difficulty alluded to by Drs. Burritt and Williams, with respect to his examining in surgical anatomy while engaged in teaching surgery, and therefore surgical anatomy, to a certain extent at least, has been removed. We are in favour of long terms of office for examiners, and would like to see them retained when thoroughly fair and efficient for ten years or as long as acceptable. If all questions of sectionalism, or personal friendships, or personal indebtedness were cast aside, and only the best available men were appointed and retained for a number of years, it would add more stability, the Council would command more respect, and the students would lose many of the doubts and perplexities which are necessarily connected with continuous and indiscriminate changes of the examiners. Although Dr. Sullivan has been an examiner for some years, we are glad that he has been appointed again, and hope he may be induced to act for many years to come, as he is admitted on all sides to be a thorough anatomist. This is a very important consideration for the

Council, because they are prohibited from appointing men as examiners in any subjects which they teach (an absurd rule by the way); and in a subject like anatomy very few, excepting teachers, are thoroughly competent to give a practical examination on the dead subject.

The students may learn from their various discussions and actions, that the members of the Council are determined that they shall learn their anatomy, and at the same time show proper respect to their examiners; and we hope that, in compliance with the plain logic of stern facts, they will during next session pay more attention to dissecting and less to petitioning.

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#### CREMATION.

Dr. C. W. Purdy, a Canadian from Kingston, Ont., who has been practising in Chicago for the last twelve years, read an interesting paper on the subject of Cremation before the Cook County Medical Society in Chicago on Monday evening, June 20th. He first gave a history of the different methods of disposing of dead bodies in the past, and showed that the process of incineration was at one time common among the Egyptians, Greeks, and Romans, but was discontinued about the end of the fourth century, on account of the growing power of Christianity, which was strongly opposed to it.

In bringing forward arguments in favour of cremation, the chief were derived from a sanitary standpoint. He contended that many serious epidemics had originated from burials in temples and churches, and asserted that the earth covering the dead bodies could not intercept the transmission of the deleterious gases into the atmosphere in the neighbourhood of the graveyards. This is a matter of serious import in large and crowded cities. Another evil of the present system was the possibility of living burial. During the last few years a tide of opinion has been setting in in favour of the old custom of incineration, which, in addition to the sanitary reasons adduced, was preferable on the grounds of economy.

Prof. Rolleston, M.D., F.R.S., of Oxford University, is dead.

#### EXECUTIVE COMMITTEE, MEDICAL COUNCIL.

The executive committee is practically dead. Its proceedings last year were generally unsatisfactory, a fact conceded by its own members. Dr. McCammon in proposing the names of the President, Vice-President, and Dr. Vernon as the Executive committee for the coming year, requested the chairman not to call a meeting before the next session of the council. It was thought advisable not to put on record any motion to this effect, although all evidently concurred. This will throw more work and responsibility on the registrar whose duties were already very arduous, and we are very glad that the council unanimously voted for Dr. Burns' motion to raise his salary from \$750 to \$1000.

We are also much pleased to notice that a sum of \$100 has been appropriated for a testimonial to the late registrar, Dr. Pyne, Sr. as a mark of appreciation of his long and faithful services to the council.

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Dr. Barnard Davis, the most indefatigable of British anthropologists is dead. His collection of crania and skeletons has passed into the hands of the Royal College of Surgeons. He was a member or Fellow of over twenty-five learned societies, British and Foreign.

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LACTOPEPTINE IN THE SUMMER DIARRHŒA OF CHILDREN.—Having in the out-patient department of our Children's Hospital, as well as elsewhere, considerable experience of the utility of this preparation in the summer complaints of children, so frequently arising from imperfect digestion of fermentescible alimentary matters, we desire to remind our readers, as the summer solstice approaches, of the efficacy of this remedy in helping, in conjunction with a discretionary diet, to procure that ounce of prevention which is said to be worth a pound of cure.

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DOCTOR-MAKING.—The *Medical Record* thinks it might locate in New York, were it not for the Latin, the following incident, taken from a French journal:—Q. Quid est creare? A. E nihilo facere. Q. Bene; te doctorem creavimus?



THE ASSOCIATION OF MEDICAL SUPERINTENDENTS OF ASYLUMS FOR THE INSANE held its 35th annual meeting at the Rossin House, in this city, on the 14th, 15th, 16th, and 17th, ultimo. There was a fair attendance of members from all parts; and the Vice-President, Dr. Callender, of Nashville, Tenn., occupied the chair with great satisfaction to all, adding to the many excellencies which justified his election to that high eminence the rarer gift of innate eloquence. We hope in our next issue to present our readers with a reasonably complete account of the proceedings of the Association, contenting ourselves in the meantime with expressing the high satisfaction we experienced in welcoming within our borders so many able and distinguished men, and especially our gratification in observing the eminent position attained amongst them by two of our fellow-countrymen, Dr. Macdonald, of Ward's Island, and Dr. Gundry, of Maryland. One of the pleasant features embodied in the valedictory resolutions we record below, reiterating on behalf of the Profession of this Province the good wishes for our Nestor therein expressed:—*Resolved*, That not the least among the pleasures attendant upon this meeting has been that of renewing personal intercourse with one of the oldest members of the Association, and one than whom none is more highly honoured and esteemed both within and without—Dr. Joseph Workman—and that it is the earnest hope of his colleagues that he may long be spared to aid them with his counsels and the public with his recognized skill and wisdom.

CANADIANS ABROAD.—DR. ALBERT E. SENKLER.—We are exceedingly pleased to record the fact that Dr. Albert E. Senkler, who left this city some 18 months ago to practice in St. Paul, Minn., has been elected third Vice-President of the Minnesota State Medical Society, and President of the Board of Censors. We congratulate our old friend and fellow-countryman upon the rapid recognition which his merits have received in his new sphere of labor, and also upon the success which his surgical skill has met with, rumours of which have reached us.

## THE CONVENIENCE OF THE TELEPHONE TO THE SURGEON.

One of the Toronto dailies recently gave an account of an accident, and in accordance with an ordinary practice in the same paper, prominence was given to some points by the use of large type, which on first glance, made it appear as follows:—

"Accident on Grand Trunk"—"Collision"—"Confusion"—"Sixty Killed"—"Blood"—"Mangled Bodies," etc.

A well-known surgeon of Toronto on seeing this went at once to his telephone, and called up the Grank Trunk, when the following conversation ensued.

Dr.—Halloo.

G. T. R.—Well!

Dr.—What about the accident?

G. T. R.—Well! what about it?

Dr.—I can go down at once if you want me.

G. T. R.—What for?

Dr.—Why, the paper says there were sixty killed and many injured.

G. T. R.—Yes, but they were pigs.

HOLMES' SYSTEM OF SURGERY AMERICANIZED.—This very valuable compendium of Surgical Theory and Practice which has been long so well-known to both English and American surgeons is, it appears, about to be re-issued in America in three volumes as a Companion to "Reynolds' System of Medicine," by Messrs. Henry C. Lea's, Son & Co., under the editorship of Dr. John H. Packard, of Philadelphia. From the prospectus we learn that each article is to be revised and brought up to date by an American of note and reputation in that department; and that the price will be about one-half that of the original.

*The International Encyclopædia of Surgery*, is another valuable contribution to the literature of surgery. Messrs. Wm. Wood & Co., are about to publish a six volume Encyclopædia of Surgery, edited by Dr. John Ashurst, jr., of Philadelphia. The articles composing which are to be contributed by distinguished English, American, French, German, and Spanish surgeons, and can be had in the English, French, or German language, at the rate for the first named of \$6, \$7, or \$8 per volume, according to binding in muslin, leather, or half-morocco.

## DOMINION MEDICAL ASSOCIATION.

We have reason to hope that there will be a good representation of the Profession of Ontario and Quebec at the meeting of the Canada Medical Association, which is to be held this year at Halifax, on Wednesday, August 3rd. It has been our pleasure to hear much of the courtesy which our brethren of the Lower Provinces have always shown to visitors from distant parts of the Dominion; and we are, therefore, glad to learn that a fair number will probably avail themselves of the opportunity afforded this year of accepting such generous hospitality. It is fortunate that those who attend the meeting will, in addition to the direct profit which they will reap from the assembly of medical men who form the Association, receive all the incidental advantages of a delightful summer trip. We shall not stop to discuss the question from this point of view, but proceed at once to give some information about the different routes available.

1st. All rail, from Toronto to Halifax and return, by Grand Trunk and Intercolonial: leave Toronto Monday morning at 7 o'clock, reach Halifax on Wednesday at 10 a.m.; leave Halifax on Thursday at 6 p.m., reach Toronto, Saturday, at 11 p.m.: fare, about \$33.00; extras, for meals, berths, &c., will make it amount to \$45.00 or \$50.00.

2nd. Part rail, part water: Toronto to Quebec, *via* G. T. R.; thence to Pictou *via* Q. and G. P. Steamer, leave Toronto Monday morning, July 25th, take steamer at Quebec Tuesday, reach Pictou Saturday, July 30th, thence to Halifax Saturday or Monday by Intercolonial; return by Intercolonial to St. John, from St. John to Portland by steamer Monday, G. T. R. to Toronto, reach Toronto Wednesday, August 9th. Fare \$39.00, including neither meals nor berths. Whole cost of trip \$55.00 to \$60.00.

3rd. Nearly all water. Leave Toronto Saturday, July 23rd, boat to Montreal, reach Montreal Sunday evening, boat Montreal Monday at 5 p. m., reach Pictou Saturday, Intercolonial to Halifax: return to Annapolis by W. & A. Railway, to St. John by steamer, to Portland by steamer, to Montreal by G.T.R., to Toronto by steamer, reach Toronto August 11th. Fare \$51.75, including everything ex-

cept berths on Gulf steamer and extras from St. John to Portland. Total cost \$55 to \$61.

4th. Mostly water. Leave Toronto Thursday, July 28th, at 11 a. m., by steamer to Ogdensburg, rail to Boston, leave Boston Saturday by steamer to Halifax, reach Halifax by Monday or Tuesday: return same way, leaving Halifax Saturday, reach Toronto Wednesday, August 10th. Fare about \$35 to \$38, including everything,

5th. As the Minister of Railways, Sir Chas. Tupper, has kindly offered still better rates by Intercolonial, *i. e.*, return tickets for one fare, another route is suggested: Steamer from Toronto Saturday July 30th, reach Montreal Sunday evening, take steamer Monday evening for Quebec, thence to Halifax by Intercolonial. Return same route. Fare about \$31; total cost about \$40.

In each trip total cost means actual travelling expenses, and, of course, does not include living at Halifax. No. 3 will make a very pleasant trip to those who can spare the required time. We understand that several expect to take either it or some modification of it. All the trips mentioned will answer the Montreal men by simply cutting off portions west of that city, except trip 4, in which they might choose their own route to Boston. In this trip (4) the Kingston men can take steamer at Kingston on Friday morning at 6:30. Further information and certificates, &c., may be obtained from the Local Secretaries, Dr. Lawson, Halifax; Dr. P. Inches, St. John; Dr. G. A. Belleau, Quebec; and from Dr. A. H. Wright, Toronto, who, on account of the illness of Dr. David, is acting as General Secretary, by request of the President, Dr. Canniff.

We regret that want of space compels us to hold over part of our Society's reports. We hope to publish the papers read at the Ontario Medical Association from time to time.

PRACTITIONER, ARNPRIOR.—The following is the formula for Mist. Rhei. c. Gentian: Rhubarb, Gentian and Orange Peel, of each, 3 drms.; boiling-water, 2½ pints; macerate for an hour and strain; then add Bicarbonate of Soda, 1 oz.; Aromatic Spirit of Ammonia, 1 oz.; Spirit of Caraway, ½ oz.



ONTARIO MEDICAL ASSOCIATION.—The Committee on "Public Health, Medical and Vital Statistics, and Climatology," consisting of Dr. Douglas, Port Elgin; Dr. Allison, Bowmanville; Drs. Playter, and Oldright, Toronto, met at the Council Hall, June 14th, and 15th. Drs. Covernton and White, the President and Secretary, were also present. It was decided that the best means of fulfilling the functions of the Committee was to issue a circular letter of questions on the above subject to the Profession throughout the Province. The compiling of the letter was left in the hands of Drs. Oldright and Playter. They divided the Province into sections, and are to be assisted by the Vice-Presidents and Local Secretaries of each division in their labours.

EXAMINATION EXTRAORDINARY. — In accordance with a resolution of the Ontario Medical Council, passed at its last meeting, Dr. John B. Hall, of this city, has been *inexpensively* examined by the Homœopathic members of that body, and pronounced be *pre-eminently qualified* to practice medicine (*homœopathically*) in this province.

CANADIANS ABROAD.—Jas. Arnott Hunter, of Newcastle, Ont., and Edmund James Armstrong Rogers, of Grafton, Ont., were admitted to L. R. C. P. and L. R. C. S., Edinburgh, at the April sittings; W. H. Burton, M. B., Toronto, took the M. R. C. S., on 16th May.

SIC ITUR AD ASTRA. The American Medical Bi-weekly says:—"Dr. Quain, who consulted with Kidd the Homœopathist, is about to receive from Her Majesty Queen Victoria the title of Baronet, in grateful acknowledgement of his obliging Her Majesty in making the consultation mentioned. *Sic itur ad astra!*"

INTERNATIONAL MEDICAL CONGRESS.—Dr. Grant, of Ottawa; Dr. Osler, of Montreal; Dr. Rosebrugh, of Hamilton; Drs. Geikie, Reeve, and Johnson, of Toronto, will represent the Canada Medical Association, at the International Medical Congress, to be held in London, England, early in August.

MALPRACTICE SUIT IN NEW YORK.—The *Medical Record* gives particulars of an action for damages fixed at twenty-five thousand dollars, which was recently brought against Dr. Lewis H. Sayre, for prescribing an overdose of nux vomica to a woman, from which she had suffered permanent impairment of health. The Dr. gave her for obstinate constipation some pills containing three grains of socotrine aloes, one grain of extract hyoscyamia, and one grain of extract of nux vomica, with directions to take one pill and repeat if necessary in four hours. The patient, however, took four pills at once, after which she was seized, as she supposed, with symptoms of poisoning; but the physician who was called in failed to recognize anything more serious than an hysterical attack. The case was an exceedingly weak one, because even if alarming symptoms and effects followed the ingestion of the medicine, the patient acknowledged that she did not follow the directions given with the prescription. It shows, however, the serious annoyance and expense to which the physician may be subjected on the most flimsy pretexts. The jury brought in a verdict for the defendant, Dr. Sayre, with an allowance to him of twelve hundred and fifty dollars.

#### APPOINTMENTS.

ELGIN BATTALION.—To be Assistant Surgeon Dr. Robert Kains, *vice* Dr. Newton, resigned.

Dr. Joseph Carbert, of Orangeville, has been appointed Jail Surgeon for the new County of Dufferin.

TORONTO GENERAL HOSPITAL.—Drs. McFarlane and Cameron have been placed on the Active Staff, Drs. H. H. Wright, and Aikins on the Consulting Staff; Drs. Ogden, and Temple have been appointed Specialists in Midwifery.

"LINCOLN" BATTALION OF INFANTRY.—To be Surgeon: Assistant Surgeon William Dougan, *vice* Augustus Jukes, who is hereby permitted to retire retaining rank. To be Assistant Surgeon: Dr. Frederick Stowell Greenwood, *vice* Dr. Dougan, promoted.

### Book Notices.

*Prize List of the Third Annual Dominion Exhibition, to be held at the City of Halifax, N.S., from the 21st to 30th Sept., 1881.*

*McGill University, Montreal 49th Annual Announcement of the Faculty of Medicine—Session 1881-1882.*

*Simple Methods to Staunch Accidental Hemorrhage.* By EDWARD BORCK, M.D., St. Louis, Mo. (Reprint from *Indiana Medical Reporter*.)

*The Differential Diagnosis of Fractures and Dislocations of the Femur at the Hip-joint.* Tabulated by H. AUGUSTUS WILSON, M.D., of Philadelphia. (Reprint from *Annals of Anatomy and Surgery*, Brooklyn.)

*Clinical Illustrations of Favus and its Treatment by a New Method of Depilation.* By L. DUNCAN BULKLEY, A.M., M.D., New York. (Reprinted from the *Archives of Dermatology*.)

*The Principles of Myodynamics.* By JARVIS S. WIGHT, M.D., Professor of Surgery and Lecturer on Physical Science, at the Long Island College Hospital. New York: Ber-  
mingham & Co., 1881.

This is a very useful little exposition of the application of mechanical laws to the bones and muscles of the human frame. The mechanical principles are first enunciated, and afterwards their application demonstrated in connection with the Hand and the Wrist-joint, the Radius and the Radio-Ulnar joint, the Forearm and the Elbow-joint, the Humerus and the Shoulder-joint, the Foot and the Ankle-joint, the Leg and the Knee-joint, the Femur and the Hip-joint, and the Skull and the Craniovertebral-joint, concluding with an account of the myometer, and of the resisting power of the Cancellous structure of bone.

This subject is too much neglected in our schools, and yet is one with which every surgeon should be practically and thoroughly familiar. The book before us is written in a clear and comprehensible manner, is abundantly illustrated, printed in large and distinct type and substantially bound. We cordially commend it to all students of Anatomy and Practitioners of Surgery.

### Meetings of Medical Societies.

#### COLLEGE OF PHYSICIANS AND SURGEONS—ANNUAL MEETING OF THE COUNCIL.

The annual meeting of the Council of the College of Physicians and Surgeons of Ontario commenced Tuesday, June 15th in the Council Hall, corner of Bay and Richmond streets. There were present:—Drs. Allison, Bowmanville; Bergin, Cornwall; Bray, Chatham; Brouse, Prescott; Buchan, Toronto; Burns, Toronto; Burritt, Peterboro'; Cranston, Arnprior; Day, Trenton; Douglas, Port Elgin; Geikie, Toronto; Grant, M.P., Ottawa; Henderson, Strathroy; Husband, Hamilton; Lavell, Kingston; Logan, Ottawa; Macdonald, Hamilton; Morden, London; McCammon, Kingston; McCargow, Caledonia; Spragge, Toronto; Vernon, Hamilton; Williams, Ingersoll; H. H. Wright, Toronto.

#### ELECTION OF OFFICERS.

The first business of the Council was the election of officers, which resulted as follows:—Dr. Bergin, Cornwall, President; Dr. G. Bray, Chatham, Vice-president.

Dr. H. H. Wright, seconded by Dr. Brouse, moved a vote of thanks to the retiring president, Dr. Allison, which was carried and recorded.

#### ADMISSION OF NEW MEMBERS.

The Secretary having reported upon elections, a committee reported that Drs. Cranston, Day, Buchan, and Wright had been duly elected members of the Council, and they were invited to take their seats.

Dr. McCargow, Caledonia, presented the petition of Dr. Book to be allowed to register without paying the fees. The petition was referred.

#### CONDOLENCE.

Dr. Grant said—In looking around this Council we observe that during the past year several changes in its membership have taken place. Some have been elevated to University chairs, some, for private reasons, are not with us to-day, but the absent one to whom I wish more particularly to draw attention at present is the lamented Dr. Mostyn, whose death you are aware resulted from accidental drowning.



During the many years he was a member of this Council we one and all enjoyed his genial disposition, his manly and upright character, and in his profession the ripe experience he possessed was of much service in the important deliberations of this body. His genuine worth was not, however, confined to this Council. For some years he took an active part in the Local House of Ontario, and advocated several measures of importance to the State. As president of the Lanark Agricultural Society, and as an active and energetic man in the growth and development of the manufacturing interests of Almonte, his genuine worth was fully appreciated. By his untimely death we have lost a warm friend and advocate of the progressive professional interests of this Council, and I am satisfied the resolution I am now about to propose is not alone the feeling of this Council, but alike the sympathetic expression of his many warm admirers in Eastern Ontario. I will move, therefore, seconded by Dr. Cranston, "That it is with feelings of the deepest regret this Council has learned of the accidental death by drowning of the late representative of the Bathurst and Rideau districts, Dr. Mostyn, and that the sympathy of this body be extended to the relatives of the deceased under the trying circumstances to which they, as well as the profession of Ontario, have thus been subjected, and that a copy of the same be engrossed and forwarded by the registrar to the relatives of the deceased."

Drs. Lavell, McCammon, Macdonald, Day, and the President eulogized deceased, and the motion was carried with a standing vote in his memory.

#### NOTICES OF MOTION.

Dr. Geikie gave notice that he would move to the effect that Council entirely disapprove of the course of Wm. Smith, a detective, having brought before the courts certain humble women in this city who have acted among the people as monthly nurses, and occasionally as midwives.

Dr. Day gave notice that he would move that application be made to the Legislature to amend the Medical Act in certain particulars.

The Council rose for fifteen minutes to allow

the committee appointed to strike Standing Committees to prepare a report.

#### STANDING COMMITTEES.

The Striking Committee reported as follows:—

*Registration Committee.*—Drs. Geikie (chairman), Lavell, Spragge, Buchan, H. H. Wright, Husband, Edwards.

*Rules and Regulations.*—Drs. Brouse (chairman), H. H. Wright, Logan, Spragge, Grant, Husband.

*Finance.*—Drs. Allison (chairman), Irwin, McCargow, Burns, Henderson, Douglas, Edwards, Cranston.

*Printing.*—Drs. McCammon (chairman), Vernon, Burritt, Morden.

*Education.*—Drs. Lavell (chairman), Grant, Geikie, McCammon, Bray, Wright, Macdonald, Burritt, Logan, Morden, Edwards, Cranston, Brouse, Williams, Burns.

Dr. Wright presented the report of the special committee appointed to revise the rules and regulations of council, which was referred to a committee.

The Council then rose.

#### EVENING SESSION.

The Council re-assembled at 7.30, the president in the chair.

#### THE CHARGES AGAINST THE EXAMINERS.

Dr. Bray presented a petition signed by a number of medical students, complaining of the conduct of certain examiners at the recent medical examinations.

Some discussion took place as to whether the petition should be received before the examiners' report, and it was finally decided to receive the petition, and it was read.

Dr. Bray moved that the petition be referred to a select committee, as follows:—Drs. Lavell, Spragge, H. H. Wright, Grant, and Bergin.

Considerable discussion took place on the motion and it was withdrawn, the Council deciding to consider it in Committee of the Whole on the following day.

#### PETITIONS.

A number of petitions were referred to the Registration and Educational Committees.

Dr. Burns moved, seconded by Dr. Edwards, that the registrar be instructed to prepare a return showing the amount of fees received by him during last year, also showing the amount paid to himself, and the amount paid to the solicitors. Carried.

On motion, the Minutes of the Executive Committee for the year were read.

During the reading a number of the delegates from the convention of the Association of Medical Superintendents visited the hall, and were invited by the President to seats on the platform.

The Council adjourned to meet in the morning, when the students' petition was to be considered.

### WEDNESDAY MORNING.

The Council met, the President in the chair.

The Minutes of the previous day's proceedings were read and confirmed.

A petition from Mrs. Elizabeth Jacobs, of London, asking for registration, was referred to the Registration Committee.

Dr. Allison moved that the registrar be instructed to furnish a return of the percentages of aggregate marks obtained by the unsuccessful candidates at the last final examinations. Carried.

Dr. H. H. Wright moved that a special committee consisting of Drs. Cranston, Burns, and Douglas be appointed to examine into and report upon the services rendered by, and the amounts paid to, Mr. Wm. Smith, the public prosecutor of the Council.

The motion was carried.

The annual report of the Board of Examiners, giving the result of the professional, final, and primary examinations held at Toronto and Kingston, and the proceedings of the Board, were read. It stated that at the final examinations there were 83 candidates, of whom 38 passed and 45 were plucked. At the primary examination 88 candidates presented themselves, of whom 41 passed and 47 were rejected. The examination was as careful as circumstances permitted.

The Council were recommended to continue the oral system of examination. The Board,

after examination, confirmed the registrar's schedules of marks obtained by the candidates. Several cases of peculiar resemblance in the answers of candidates on certain subjects were referred to the consideration of the Council.

The report was received and referred to the Committee of the Whole.

### NOTICES OF MOTION.

Dr. Allison—That in future no examiner, after having been appointed for one or two years, shall be eligible for another term immediately succeeding, but that an interval of two years must elapse before he can again officiate as examiner.

Also—That the examination papers for the final and primary examination must in future be submitted and approved by a committee of three of the executive committee.

Dr. Macdonald—Motion expressing disapproval of the prosecution of women for non-registration, etc., until the medical status of women is recognized by the Council and the Act.

### THE CHARGES AGAINST DR. SULLIVAN.

The Council went into Committee of the Whole on the petition from certain unsuccessful students at the recent examinations, Dr. Allison in the chair.

Dr. Brouse said that in the absence of Dr. Bray, who had presented the petition, he would make a few remarks on the document. There were certain grave allegations put forth in it which required investigation. The matter had an interest not only for the students and the Board of Examiners, but for the community at large. He regretted exceedingly that Dr. Bray was not present to say how he wished the council to deal with the matter. It was one that must be dealt with, having gained notoriety through the columns of the city newspapers. The conclusion they arrived at, if the prayer of the petitioners was granted, might be used as a precedent for reopening the question of examinations whenever the results were unsatisfactory to the candidates. It was desirable to have all the facts brought out, so that they would be able to ascertain whether the charges made against one of the most efficient examiners whom the Council had



secured were true or not. The petitioners alleged that the examiner had failed to do his duty towards them and the Council, and they asked for redress. He knew not the names of the petitioners, but was aware that some of them stood apparently very high in all the branches of study, save one. It was, doubtless, very peculiar that so many of the candidates should have failed in this particular branch. It might be that the colleges had failed to educate their students in anatomy, or there might be some other cause for the unsatisfactory result. Whatever the causes they should be investigated. It was for the schools to show how they had discharged their duty, and for the examiner in anatomy to show how he had conducted his examination.

Dr. Macdonald said that a large amount of dissatisfaction existed among the students, and no doubt such a feeling would always arise when the failures to pass the examination were numerous. But allegations were made in regard to matters of fact. It was stated that the examiner gave the pupils no time either to examine the "subject" or to think of the answers they should give to the questions put to them, and that when the candidates hesitated in answering a question, the examiner used profane language. These things required to be investigated. He thought it would be desirable to have a personal examination of some of the individuals who could testify on these points. Would it be necessary to examine the young men who made the charges?

Dr. Lavell said that if the suggestion was pressed he should move that the petitioners should be examined face to face, not only with one examiner, but with the whole Board of Examiners.

Dr. H. H. Wright said that the Council had no precedent for action in a case like this. If they knew what course was taken by the universities and colleges when dissatisfaction was expressed by students with their examinations there would be something to serve as a guide.

Dr. Williams said that one of the features of the present case was that charges were directly made against Dr. Sullivan which, if true, showed very improper conduct on his

part. He did not think that it was necessary at that time to investigate these charges. The proper time would be when Dr. Sullivan came up for re-appointment. He would suggest that the case of the students be alone considered. The law said that the examinations might be held at Toronto or Kingston in such manner and at such time as the Council might direct. No authority was however given to hold an examination at both places, and in this matter the Council had, perhaps, stepped beyond their rights, and thus laid the foundation for grievances. It was said that a different quality of paper was used at Toronto from that used in Kingston, and this, if true, put the examiners to the risk of being reflected upon. He knew of no good reason why the examinations should not have been held at one place only. Dr. Sullivan was advertised as teaching surgical anatomy, and this in direct defiance of the rule which provided that no teacher in any school in Ontario could hold the position of examiner in the subject on which he lectured. It was no wonder that the students should be dissatisfied on finding that the Council had violated its own rules, enacted for their protection. Then the rule laid down in the annual announcement of the College was that students would be required to get 60 per cent. in the aggregate of the marks possible, and those who had obtained this average had a right to their licenses. Many of the unsuccessful students on this occasion had obtained an average of 75 per cent.

Dr. Macdonald said that this was not the first time that charges had been made against their examiners. It was possible that Dr. Sullivan might have got out of patience with some of the candidates, and had expressed himself rather warmly. The question as to what college certain students belonged, if put at all, might have been prompted by the same cause. Dr. Sullivan was advertised as the lecturer on surgery, and it was hardly possible for a man to lecture on surgery without touching upon surgical anatomy. As to the claim that those who obtained an aggregate of 60 per cent. of marks were entitled to a pass, he could only say that the intention of the Council was, that if a candidate failed in one subject he should

be rejected. As to Gray's anatomy, a student might know it by heart, and yet not be a practical anatomist. Dr. Sullivan was a practical anatomist, and would express his impatience of mere theoretical knowledge.

Dr. McCammon inquired if all the parties who had signed the petition were at the recent examinations.

The Registrar said that seven of them were not examined at all.

Dr. McCammon remarked that in that case one quarter of the number of petitioners were not interested in the examinations at all.

Dr. Burritt thought if only three of the candidates had signed the petition, it should be investigated. He agreed in the view taken that the Act declared that no lecturer should examine in the subject on which he lectured. No man was more competent to examine in surgical anatomy than Dr. Sullivan, but still his appointment was a violation of the law. The other allegations, he thought, should be considered in Dr. Sullivan's presence. It was, no doubt, a singular coincidence that the papers used at Toronto were of a different colour from those used at Kingston, and that of the candidates plucked in the particular branch referred to none of them were Kingston students.

Dr. Williams moved a resolution declaring that the rule in reference to the percentage of marks to be obtained implied 60 per cent. on the aggregate, and that all candidates having obtained that percentage at the late examination be registered as having passed.

Dr. Bergin said that in the course of the discussion such a cloud of dust had been thrown up, and so many queer statements been made, that he felt it his duty to say a few words. He regretted that any such discussion had been necessary at all at their meetings. It was not in the interests of the students, as he thought would be shown very plainly before long. It was not in the interests of the men who prompted the students to make these charges, and not in the interest of the profession at large, or in the interests of the public. The Council were asked to treat the examiner in surgical anatomy, whom they had chosen for his eminent attainments and fitness

for the post, with gross indignity. They were asked to bring him face to face with students who wanted to get rid of the consequences of their ignorance, to bandy words with them on the floor of that chamber. Would they be consulting their own dignity by consenting to such a proceeding? He protested against anything of the kind. It was true the gentleman assailed—and he had been violently assailed in the public press—asked to be brought face to face with his accusers in order to show that the charges made had been provoked by men who should have scorned to associate themselves with such a transaction. The charge of profane language was the last which should have been made by the students. He could easily understand that an examiner, provoked at the exhibition of gross ignorance by those who presented themselves for a practical examination, might use some strong language. Dr. Sullivan was appointed because it was the desire of the Council that there should be an end to the sham examination on the subject, and that henceforth every successful student should possess a thoroughly practical knowledge of anatomy. They knew that in times past students had only that parrot-knowledge gained from books and plates, and needed that practical business knowledge gained from a proper study of the "subject." Dr. Williams asserted that the Council intended that a 60 per cent. aggregate of marks should pass a candidate. The Council had never any such intention. The announcement stated that the candidate must pass at a future examination in the branches in which he failed. He did not believe that the man who made the charge against Dr. Sullivan about the colour of the paper ever thought that it was true. Dr. Sullivan had told him that the first intimation he had got of the difference in the colour was after the examinations were over, and when he had left the city. The fact that the petition purported to be signed by unsuccessful candidates, when it was found that many of the petitioners were not candidates at all, was very damaging. Persons who commenced by asserting a falsehood ought not to complain if their petition was treated with contempt. They were giving the petition a consideration which it did not



deserve. It should not have been discussed in this public way, but have been referred to a special committee. (Hear, hear.) After having considered the allegations, he thought the committee would have recommended that no action be taken. It was not true that none of the pupils in Dr. Sullivan's school were rejected. Men were rejected in that school. Men were rejected too in other branches, and their rejection was due to their ignorance, and not to any undue severity on the part of the examiners. They had been told by these fledglings who wanted to dictate to the examiners that the questions were not of a practical character. Were the candidates to be the judges as to the character of the questions to be put to them? Were the positions of examiners and the examined to be reversed? He had thought the Council had been established for the purpose of advancing the interests of the profession by excluding half-educated men; but it seems he had been mistaken. Judging by the petition, the sole object of the Council was to pass students who paid so much money at the end of their little term, whether they were qualified or not. If the Council would not pass them, they rushed to the public press and slandered and vilified the gentlemen who discovered their ignorance. It would be better that the Council should be dissolved; better that they should die with honour than submit to degradation of this kind. If they entertained the proposition to bring the examiner and the students face to face, did they think they would ever get a man of character to accept an appointment as examiner in the future? One of the gentlemen who professed to be so horrified at the profanity of the examiner, once asked him (Dr. Bergin) "What in hell do you know about anatomy?" Well, he had an opportunity of examining that man orally on the subject, and he found out what he knew about anatomy. (Laughter.) He, however, did not know at the time of the examination that the candidate was the person who had used this choice language. But subsequently the man acknowledged he had acted a coward's part, and said he had been driven to it by a teacher in the school. He (Dr. Bergin) wished he knew the name of the teacher, for

he would have published the name of the coward from one end of the country to the other. He fancied he recognized the same language in one of the paragraphs of the petition as that used against him. Dr. Sullivan, he might say, had adopted a rule at the examination which prevented him and the Board of Examiners from knowing the names of the candidates. Dr. Sullivan had plucked his own pro-sector, so impartial and thorough was the test he applied. In conclusion, he proposed that the discussion be removed from the open Council to a private meeting, and he hoped some member of the Council would move to that effect.

Dr. Williams advocated further discussion. He would not allow the principle that the conduct of examiners was to pass unchallenged.

Dr. Lavell also advocated further discussion.

Dr. Geikie held the same view. He could not help thinking that a good deal of froth had been blown up that morning. He fancied they could come to a decision without assailing any one.

Dr. Lavell said that charges had been made which did assail character, and they must be met.

Dr. Logan moved that the Committee rise and ask leave to sit again in the afternoon. Carried.

The Committee rose accordingly.

The Council adjourned till the afternoon.

#### AFTERNOON SESSION.

The Council re-assembled at two o'clock.

The discussion in Committee of the Whole on the students' petition was resumed.

Dr. Macdonald called attention to section 1, paragraph 7, of the announcement, which explained that candidates who failed to pass in any subject should be compelled to pass in it at a future examination. He contended, therefore, that the sixty per cent. of the marks required did not refer to the aggregate.

Dr. Geikie disclaimed entertaining any personal feeling on the one side or the other. He viewed the matter from a Council stand-point, and the well-being of the Council depended upon their action in the matter under discussion. He thought it was bad policy to abuse either

the examiners as a body or the medical students as a body. He found on page 16 of the announcement the following regulation:—"No teacher in any school of medicine in Ontario can hold the position of examiner in the subjects upon which he lectures, or upon which he may have lectured within one year prior to the date of the examinations." The question was, had this rule been contravened? He thought that it had, because the announcement appeared in Kingston that Dr. Sullivan would lecture on surgery, including surgical anatomy. He quite believed that Dr. Sullivan conducted the examination with perfect fairness, but still it would be said that the pupils of Dr. Sullivan, who had the advantage of his oral teaching, would have in being examined by him an advantage over their fellow-students. They had to remove even the shadow of a doubt as to the perfect equality of all students when under examination. The students would not complain of the severity of the examination if they believed they were all placed on the same level.

Dr. H. H. Wright moved that a special examination be given those students who were rejected this spring in certain subjects, at which they may present themselves for final examination.

Dr. Grant said it was all very well to say that because Dr. Sullivan examined, the unsuccessful students did not pass. It mattered not who examined, the students who had no practical knowledge of the subject of anatomy would have been plucked.

Dr. Geikie—Do you think it of no importance that the printed rules should be observed?

Dr. Grant—Most assuredly.

Dr. Geikie—Well, that is my point.

Dr. Lavell thought that when medical students complained of profanity, there must be some sarcasm in the complaint. He proceeded to say that at the final examination only four out of the thirty-eight candidates who passed gained 60 per cent. on each subject; six were below 60 per cent. in anatomy, and gave further analysis to show that the standard was low. Dr. Sullivan's standard in surgical anatomy was 40 per cent., and surely a student should come up to that low standard. He enumerated the

questions put by Dr. Sullivan, and put it to the Council to say whether they were reasonable and moderate. He would, however, cut out half the questions, and then he would contend that a student who could not make 40 per cent. out of the remaining four questions deserved to be plucked. It was no fault of the schools that the students were so ignorant of practical anatomy, but of the students themselves in not applying themselves to dissection. The grumbling at the anatomy examination was no new thing; their previous examiners had been insulted by students who had not passed. Out of the forty-three rejections, it turned out that Dr. Sullivan had only rejected twelve in surgical anatomy, and every one of these was under 38 per cent. of the total number of marks. Then the responsibility of the rejection was not confined to Dr. Sullivan, as the whole board had the power of revising the verdict if they perceived anything unfair. They, however, adopted Dr. Sullivan's report. Twelve gentlemen were rejected in subjects independent of anatomy, and nineteen on other subjects with anatomy, so that out of the forty-five rejected men thirty-four would have been rejected even if Dr. Sullivan had not been at the examination at all. This indicated that a dead set had been made at one man. Finally, Dr. Sullivan had not lectured on surgical anatomy for years, the printed announcement being a mistake. Therefore none of the students had the advantage of Dr. Sullivan's teaching in surgical anatomy. It had been said that Dr. Sullivan had favoured his own students, but no one who knew him would believe him guilty of such dishonesty, and the man who made such a charge was capable of anything. He thought the Council should refuse to entertain a petition containing such monstrous charges. It had been said that the malignant letters to the newspapers had been inspired, and that the students in the Toronto hospital had been harangued by one of the teachers in reference to Dr. Sullivan. Dr. Sullivan had been treated in a cruel way, and the foul aspersions made on his character could not fail to injure him. Dr. Sullivan was willing to submit the examination papers and their answers to any anatomical authority and abide by his decision. He was not, however, willing



to take more than his proper share of responsibility for the total number of rejections.

Dr. McCammon said that the allegation made in the petition that dissatisfaction existed among the students was a falsehood. Dr. Sullivan denied that he had denounced any student with profane language, or that he had not given the candidates sufficient time to answer the questions, or that he had asked the candidates to which college they belonged, except to compliment those who had passed. Finally, Dr. Sullivan did not lecture on the subject of surgical anatomy. He thought that the co-examiners of Dr. Sullivan should have come forward and said that they were as responsible as Dr. Sullivan. The young men who found fault with the examiners were those who failed to pass, and spent the time they should have been in college in saloons and theatres. It was the duty of the council to sustain the examiners, if they wished to elevate the standard of the profession. He wished to know from the Registrar who applied for the marks quoted in the petition?

The Registrar said he supplied only the marks of the rejected candidates. The marks of the pass-candidates could have been given by one of the examiners, as they took a copy of the schedules compiled by the Board of Examiners.

Dr. Allison thought that probably the examiners themselves were to blame for giving the information.

Dr. Geikie said he knew not who signed the petition, but if there happened to be a majority from any school, it was the result of accident.

Dr. Bergin said one insulting statement in the petition was that Dr. Sullivan had acted in the interest of a minor school. Now it appeared that the result of the examination had been to the credit of McGill College, and not of his school. If the same test were applied to the other examiners, it might appear that they acted in the interests of their schools, but no such despicable charge would be made against them. He gave an analysis of the result of the final examination, showing that Dr. Sullivan could not have favoured his own school.

Dr. Macdonald thought the use of Gray's Anatomy led to the unsatisfactory result of the

examination. He would advise the students to abandon Gray. Anatomy, should, in fact, be studied off the subject. He would ask the students present if they would withdraw the petition.

Dr. Geikie thought it would be a judicious thing to withdraw the petition, especially as there were names on it of persons who were not present at the examination.

Dr. Bergin thought that the students should ask leave to withdraw the petition. He did this because he believed the students had been ill-advised. He had been requested by several of the students who signed the petition to make the request.

Dr. McCammon said he had been informed by the students that they did not intend to withdraw their names.

Dr. McCargow, seconded by Dr. Day, moved that the petition under discussion, reflecting upon the character of Dr. Sullivan, be rejected.

Dr. H. H. Wright protested against this method of ignoring the rights of the students.

Dr. Bray moved, seconded by Dr. McCammon, that the petition be referred to a committee, consisting of Drs. McDonald, Bray, Burritt, Williams, Douglas, and the mover and seconder. Carried.

The Council adjourned.

#### EVENING SESSION.

On the re-assembling of the Council, the following petition was received:—

"The undersigned most respectfully beg, on behalf of the rejected students, permission to withdraw their petition relating to the late examinations, requesting you to take into consideration their position and deal with them as in your wisdom seems proper, and your petitioners, as in duty bound, will ever pray. A. H. Ferguson, W. F. Peters, W. A. D. Montgomery, J. F. Howitt, W. H. Aikins."

Dr. Lavell inquired from the President if this withdrawal was also a withdrawal of the charges against Dr. Sullivan.

The President replied that it was his opinion that the charges were thus withdrawn, and the students simply threw themselves on the consideration of the Council.

The petition was, therefore, received, and the Council adjourned and the Committee went into session.

#### THURSDAY MORNING.

The Council met, at ten o'clock, Dr. Bergin in the chair. After the reading of the Minutes, Dr. Allison moved that in future, after the present year, the examiners shall not hold office longer than for two years at a time. The mover said that he did not desire, by his motion to censure the present examiners, but he strongly believed that it would be in the interests of the profession to distribute the office of examiners as suggested by the motion. Dr. Wright moved, seconded by Dr. Lavell, that it be referred to the Education Committee. This was carried.

#### NOTICE OF MOTION.

Dr. Edwards—That in future the names of all students undergoing any of the examinations before the College of Physicians and Surgeons be withheld from any and all of the examiners, and that it shall be the duty of the Registrar to publish, so soon as practicable after the final adjudication by the examiners, a complete list of all the successful candidates, and that no percentage be given to any candidate except to a rejected one, and that only on the subject on which he is rejected.

#### FRIDAY MORNING.

The Council met, the President in the chair.

The Minutes of the previous day's proceedings were read and confirmed.

The Council adjourned till four o'clock to allow the committees to consider their reports.

At 12 o'clock the members of the Council went to the General Hospital, where Dr. Aikins shewed the working of the Galvano-Cautery, and Pacquelin's Thermo-Cautery, and an amputation of the arm performed under Lister's Carbolic Spray.

At the afternoon session Dr. Aikens was re-appointed treasurer, Dr. Pyne registrar, and Mr. Dalton McCarthy, Q.C., solicitor.

Dr. McCammon moved that Drs. Bergin, Bray, and Vernon be the Executive Committee for the year. The motion was carried.

The Education Committee submitted their report, recommending various alterations in the announcement of the college. Among them were the following:—The substitution of the High School intermediate examinations for the matriculation examination of the college, the making of the final professional examinations to correspond with written and oral examination, and a clause providing that half the fees should be returned to unsuccessful candidates, and that the full fees be paid for subsequent examinations. The report also recommended the appointment of the following examiners for 1881-2:—

Dr. M. Sullivan—Descriptive Anatomy.

Dr. F. R. Eccles—Medicine, General Pathology, and Sanitary Science.

Dr. Fulton—Midwifery.

Dr. G. A. Tye—Physiology and Histology.

Dr. W. P. Buckley—Surgery and Surgical Anatomy.

Dr. Barrett—Chemistry and Toxicology.

Dr. W. W. Dickson, Pembroke—Materia Medica, Therapeutics, and Botany.

Dr. Nichol, Brantford—Medical Jurisprudence.

Dr. J. Gilbert, Stratford—Homœopathic Examiner.

The percentages to be gained in each subject were fixed by the Committee in proportion to their importance.

The report was adopted.

The Council adjourned till 7.30. p.m.

#### EVENING SESSION.

The Council resumed business at 7.30, Dr. Bergin taking the chair.

Dr. H. H. Wright moved, in pursuance of notice "That the registrar, as part of his duties, shall examine all credentials of candidates presenting themselves for examination, and accept or reject the same as they comply, or do not comply, with the by-laws, rules, and regulations of this Council; also do prepare a programme, and have it sanctioned by the President."

Dr. McCammon seconded the motion, which was put and carried.

#### THE PROFESSIONAL EXAMINATION.

Dr. Macdonald moved, seconded by Dr. Burns, "That all those students who in the late



professional examinations have made 50 per cent. of an average on the aggregate, not less than 40 per cent. as the minimum, on any two subjects, and not less than 30 on any subject, be granted the license of this college."

Dr. H. H. Wright moved in amendment, seconded by Dr. Bray, "That a special examination be ordered, to be held early in July of this year, at which all students who failed in their final examination in April of this year may present themselves for re-examination, and that such examination shall be oral, the written examinations already in possession of this Council forming part of the evidence of attainments of such candidates, and that the details of such special examination be determined by the executive."

The President said he was under the impression, although he was not prepared at present to rule, that both motion and amendment could not legally be carried into effect; that in fact it would be a violation of the Medical Act to do so.

A general discussion took place on the subject, several members appealing for a liberal treatment of the repentant students, who had withdrawn their petition, and consequently stood in the position in which they were before they petitioned. Other members, including the President, contended that the authority of the Council should be upheld.

After some explanation the President ruled that both the motion and amendment were in order. He, therefore, proceeded to call upon the Council to vote upon them.

Dr. Lavell asked to be excused from voting on the motions—the reason for which he felt satisfied the members of the Council would appreciate; and he was excused accordingly.

The amendment was then put and the vote declared yeas, 10; nays, 10.

The President gave his casting vote with the nays and declared the amendment lost.

The main motion was then put and declared lost, on a division of 9 yeas to 11 nays.

#### EXECUTIVE COMMITTEE'S REPORT.

Upon the motion being put for the adoption of the Report of the Executive Committee presented on Thursday, granting among other

things permission to thirty-five students to register who were rejected by the matriculation examiners, but who have since passed their professional examinations.

Dr. Lavell said he was most decidedly opposed to the proposition to sanction the action of the Executive Committee, because they had no right to act as they had done; but while he would be prepared to allow the students their time, still he would insist upon them passing a thorough examination. If this were not done the public would lose confidence in the Council. Look, for instance, at the papers of those young men who were originally rejected at their matriculation, but afterwards passed by the Executive Committee; they had only ten and twelve marks in some subjects out of the necessary forty-five required in order to entitle them to pass their examination, entitling them to enter upon the study of their profession.

Dr. McCammon moved an amendment in opposition to the adoption of the report, but he withdrew it after Dr. Macdonald had addressed the Council in support of the adoption of the Executive Committee's report.

The motion was then put and the report was adopted. Yeas, 13; nays, 7.

#### REGISTRATION.

Dr. Geikie, chairman of the Registration Committee, reported that Dr. J. B. Hall, homœopathic practitioner in this city, be allowed to register in this college, provided he pass the examination before the homœopathic members of the college, as an inexpensive method of testing his attainments.

Dr. H. H. Wright moved, seconded by Dr. Lavell, that the Council go back into Committee of the whole to amend the Report by inserting the following words:—

That Dr. John B. Hall shall be admitted to Registration in the usual way, viz.:—by undergoing the usual examinations, and in the usual way. *Lost.*

VOTE.—*Yes.* Dr. Burns, Lavell, Williams, and H. H. Wright.

*No.* Drs. Bray, Burritt, Cranston, Douglas, Edwards, Henderson, Husband, Logan, Morden, McCammon, and McCargow.

The report was adopted.

## THE MEDICAL ACT.

A Committee was appointed to wait upon the Ontario Legislature, praying that body to so amend the Medical Act as to provide for the representation at the Council only of bodies actually engaged in teaching, and bodies granting degrees; also the homœopathic body and the territorial divisions.

The motion was passed, but the time for appearing before the Legislature was not named.

## ANNUAL ASSESSMENT.

On motion, it was decided that the annual assessment should be one dollar.

## REGISTRAR'S SALARY.

A by-law was introduced and passed providing to pay the registrar the sum of \$1,000 per annum.

## TESTIMONIAL TO THE LATE REGISTRAR.

A resolution was unanimously carried appropriating the sum of \$100 for a testimonial to the late registrar, Dr. Pyne, sr., as a mark of the Council's appreciation of his long and faithful services, and a committee was appointed to present the said testimonial.

## NOTICE OF MOTION.

Dr. H. H. Wright gave notice that he would move at the Council next year that the annual attendance of students at medical schools should be in future eight months, instead of six, as at present.

After transacting some routine business the Council was brought to a final close at 11.30, the usual hand-shaking was indulged in, and the members took their departure for their respective homes, evidently well pleased at the termination of the proceedings.

GONORRHOEAL RHEUMATISM. — A surgeon major A.M.D. writes to the *British Medical Journal* recommending the following prescription:—

R. Sodæ salicylatis .....	ʒijss.
Olei santali flavi .....	ʒss.
Tincturæ actææ racemosæ ...	ʒiij.
Tincturæ cardamomi comp...	ʒi.
Mucilaginis ad .....	ʒviiij.

M. Half an ounce to be taken three times daily.

## ONTARIO MEDICAL ASSOCIATION.

The inaugural meeting of this Association was held in the Hall of the College of Physicians and Surgeons, Toronto, on the 1st and 2nd ult. This initial Convention proved a decided success both in point of numbers and the harmonious and interesting character of the proceedings. A very gratifying enthusiasm prevailed at all the meetings, and all departed seemingly pleased and satisfied. Under the circumstances, therefore, we cordially felicitate the promoters of the enterprise upon the very gratifying success which has attended their efforts, and bespeak for the Association a vigorous existence, a widespread utility, and an enduring local renown.

The Meeting was called to order at 11 a.m., by the provisional chairman, Dr. Covernton, of Toronto, who made the following remarks:—

GENTLEMEN,—It may be enquired by some members of the profession "Why multiply associations?" We have already in successful operation County and Dominion organizations that have done good work. Whence the necessity for a Provincial one? The members of a Committee of the Toronto Medical Society, acting conjointly with a deputation from the Hamilton Medical Society, arrived at the conclusion that the answer was not far to seek. From a patriotic point of view we may rejoice with our American cousins that—

"No pent-up Utica confines our powers,  
A boundless continent is ours."

This immensity of space, however, has its disadvantages, even in this age of railroad travel and communication by telegraph and telephone. A Dominion Society necessarily is a peripatetic one; the meetings having been convened yearly at points intermediate between Halifax and London in the past. In the probably not distant future Victoria or New Westminster may be the Pacific limit. The long summer or early autumn holiday which attendance on these distant points would involve, would doubtless be very desirable and enjoyable to the hard-worked practitioner, who of all men should revel in it if the pleasure and benefit are to be in any way dependent upon the previous mental and bodily strain of a year's practice. A holiday to be thoroughly appreciated must have



been worked for, and certainly no class of men can be said to better earn one ; but withal the emolument resulting from the labour is not such as to leave a large margin for pleasure, even when combined with the professional advantages resulting from association with their brethren.

Admitting then, as I fear we must, this frequent "*Res angustæ domi*," it necessarily follows that but comparatively few Ontario members of the Dominion Association can attend the meetings when convened either at Montreal, Quebec, or Halifax, and the same disadvantages are felt by the Quebec or Gulf Province members when a distant point is settled on. The result then has been that practically the meetings have been more Provincial than Dominion, whilst the interest taken in them under the latter name, was not equal we conceived to what it would be under a distinctly Provincial character. The question meets us at the very threshold. What are the real aims and objects of such associations? The answer we concur would certainly be that the main design is the furthering of practical knowledge and skill, the requiring from all its members scientific aims and objects, the repudiation of those who view practice only in the light of a lucrative business, and the discountenancing all devices calculated to be the means of levying a tax on the hopes and fears of the ignorant and credulous. These brief reasons for the existence of such associations, if accepted as correct, naturally then require an extensive enlistment of members for the accomplishment of the objects aimed at. The various city and county Medical Associations have done much towards the furtherance of the purposes named, but their influence is but local, and circumscribed, and they have contributed comparatively little towards uniting the profession in harmonious action.

Such comprehensive working, we hope in time to obtain through this Provincial incorporation, trusting that the sister provinces will manifest an equal zeal and judgment in promoting the advancement of professional knowledge by the inauguration of similar Provincial societies, and that from these various associations there will be annually elected a large

number of delegates to the Dominion Association. This Dominion Society will thus yearly include in its ranks the ablest and best men in the profession, and would in this manner be in communion with the whole fraternity.

From the transactions of these various societies, which we trust will be yearly bound up with the reports of the Dominion organization, a rich mine of scientific researches, important facts, and reliable medical data, and investigations, may be fairly expected, and through these channels the professional acquirements and latent literary powers of many members of our profession be educed.

It may, perhaps, be considered that as Chairman of the Provisional Committee, I am, in picturing a future of the new society, trenching upon the ground that more strictly belongs to the President, this morning to be elected ; if so I can only plead in excuse the desire to remove from the initiators of this new institution any charge of action detrimental to the Canada Medical Association. We have contemplated only an offshoot, not a rival, but a sister institution, and while we hope it may flourish with an exuberant growth, we do not conceive it likely to diminish in the slightest degree the interest which the profession have always taken in the parent society.

A prolix Chairman, gentlemen, may be possibly considered as great an affliction as an instrument out of tune, I will, therefore, shorten your sufferings as listeners, by passing on to what is more germane to my present position, viz., the reporting of the preliminary work done by the Joint Committee of the Toronto and Hamilton Medical Societies. With a view of saving time when the members of this new society met in convocation, a draft of the Constitution and By-laws was prepared, which will now be submitted for either your approval or modification, by Dr. White, the provisional Corresponding Secretary, to whom we are greatly indebted for unfailing zeal and much time given in the working out of the numerous preliminaries inseparable from the successful floating of a new society—a society which in time, we trust, may take rank with those long in existence in the United States and on the continent of Europe. To the Medical societies

of Toronto, Hamilton, and Peterboro' may be assigned the initiation of this effort. Upon you, gentlemen, now devolves the successful completion, and I have no doubt that the requisite earnestness of purpose will not be found wanting for the consummation of so desirable an end.

The first in order of business will be the enrolment of members. I may here mention that in view of the numerous society subscription calls, it was deemed judicious at the informal Committee-meeting to fix annual dues at \$2.00, those present, paying, at the time the sum named. It is for you to determine whether that or a larger subscription fee shall be charged.

The first order of business was the enrolment of members, about 100 (subsequently increased to 127) signing the book. The constitution and by-laws (as adopted by the conjoint committee from Hamilton and Toronto) were then read by the Provisional Secretary, Dr. J. E. White, and, after considerable discussion and some modification, adopted. (The Constitution and By-Laws will be printed together with a list of the officers and members, and a copy will be furnished to each member. Members of the profession who have not yet joined the Association can secure copies on application to the Treasurer, Dr. J. E. Graham, or the General Secretary, Dr. J. E. White, Toronto.)

A committee was then appointed consisting of Drs. McDonald, Hamilton, G. Wright, Burns, Fulton, Toronto; Yeomans, Mount Forest; Carney, Windsor; Allison, Bowmanville; Campbell, Seaforth; Hamilton, Port Hope; and Rosebrugh, Hamilton, to nominate the officers for the society, and to report at the afternoon session. The meeting then adjourned until 2 p.m.

#### AFTERNOON SESSION.

Although the hour fixed for the afternoon session was two o'clock, the meeting was not called to order until three, those present being interested in examining a display of surgical and other instruments which were on exhibition. The Report of the Nominating Committee was then presented, and the following officers were elected unanimously, viz. :—

President, Dr. Workman, Toronto; 1st Vice-President, Dr. Irwin, Kingston; 2nd Vice-President, Dr. Tye, Chatham; 3rd Vice-President, Dr. Macdonald, Hamilton; 4th Vice-President, Dr. McMillan, Alexandria.

General Secretary, Dr. White, Toronto; Treasurer, Dr. Graham, Toronto.

Corresponding Secretaries—Dr. Stewart, Brucefield; Dr. Woolverton, Hamilton; Dr. Hamilton, Port Hope; Dr. McDonald, Alexandria.

#### STANDING COMMITTEES.

Committees on Credentials—Dr. Pyne, Toronto; Dr. McGregor, Chatsworth; Dr. Beeman, Centreville.

Committee on Public Health—Dr. Douglas, Port Elgin; Dr. Flayter, Toronto; Dr. Allison, Bowmanville; Dr. Oldright, Toronto.

Committee on Legislation—Dr. Ecroyd, Mount Forest; Dr. Spohn, Penetanguishene; Dr. Sloan, Blyth; Dr. G. Wright, Toronto; Dr. Covernton, Toronto; Dr. Mullin, Hamilton.

Committee of Publication—Dr. Fulton, Dr. Cameron, Dr. Burns, Toronto; Dr. White, secretary, and Dr. Graham, treasurer, permanent members.

Committee on By-Laws—Dr. Bray, Chatham; Dr. A. H. Wright, Toronto; Dr. Moore, Tamworth; Dr. Tanner, Holstein; Dr. Cotton, Mount Forest; Dr. Bowlby, Berlin.

Committee on Medical Ethics—Dr. Ghent, Priceville; Dr. C. O'Reilly, Toronto; Dr. G. McKelcan, Hamilton; Dr. Carney, Windsor; Dr. C. K. Clarke, Hamilton; and the place of meeting to be Toronto.

After the election of officers, Dr. Workman, on being called to the chair, and after expressing his sense of the dignity and importance of the office, and his appreciation of the high honor which had been conferred upon him in calling him thereto; and after according due acknowledgments to the labours of the Preliminary Committee, and especially its Hamilton members, went on to say that he was entirely at a loss to know the reason for his selection, unless, indeed, it had been remembered that he once lectured up on midwifery and it was hence supposed that he was thereby qualified to preside at the birth of the new association. But



another suggestion occurred to him, perhaps all the members had *repente* become homeopaths, and, calling to mind the fact that he had for a long time presided over a lunatic asylum, they at once applied the doctrine of *similia similibus*, and chose him to preserve order amongst them. However, whatever their reason might be, it was apparent that all were anxious to commence the real business of the meeting, and without further prelude he would take the chair.

Drs. Osler and Buller, of Montreal, being present were elected members by invitation.

The first paper read was on Primary Tuberculosis of the Larynx, by Dr. L. L. Palmer, of Toronto, which elicited an interesting discussion at the hands of Dr. Graham (Toronto), Macdonald (Hamilton), Bowlby (Berlin), Hamilton (Port Hope), and Sloan (of Blyth).

Then followed Dr. Groves (Fergus) on Suprapubic Lithotomy, reporting two cases. Drs. Canniff and Palmer took part in the discussion.

Dr. Oldright showed an interesting hip-joint specimen, exhibiting a filled-up acetabulum, false joint, absence of head of femur, with a round prominence beneath anterior superior spine of ilium strongly resembling the head of the femur, attached by bony union and showing cancellous structure on section, another small rounded bony prominence beneath this, a fracture of the os pubis and of the ischium. He detailed the history, the case being one of 55 years standing, and read a letter from Dr. Frank H. Hamilton, of New York, to whom the specimen had been submitted and who admitted the osseous prominence might be either an osteophyte or the head of the femur, but seemed to be inclined to the former opinion.

Dr. Osler thought from its appearance and cancellous structure that it was the head of the bone. Dr. Canniff took the same view. Dr. Cameron found it difficult to account for the position of the head of the femur, and also for its having maintained its vitality in that situation, separated from the neck, and its attachment by its edge and not the supposed fractured surface. He quoted Rindfleisch to show that its cancellous structure was not an insuperable objection to its

being an osteophyte, and only admitted it to be the head of the bone on having discovered recently that Bennett, of Dublin, had found two similar specimens in connexion with the shoulder-joint. Dr. Ross, sen., suggested that at the time of the first injury there had been an impacted fracture of the neck together with supraspinous dislocation, that the head had become united by bony ankylosis in its false position, and the impaction had subsequently given way, allowing of the return of the neck and shaft to a more normal situation.

Dr. King then read a paper on Progressive Pernicious Anaemia, and Drs. Osler (Montreal), and Graham (Toronto), took part in the discussion.

Dr. Curry, of Rockwood, contributed an amusing and telling paper on "The Science of Medicine and Common Sense," which elicited much laughter and applause.

Dr. Roseburgh, of Hamilton, exhibited two new pessaries, designed to remedy anteversion and antelexion with descent, narrating his views on these conditions and the *modus operandi* of his invention. Drs. Ross, sen. (Toronto), Tye, (Thamesville), and McGregor (Chatsworth), made some remarks.

Dr. Coburn (Oshawa) reported a case of Aneurism of the Transversalis Colli, treated by elastic compression with gratifying success.

Dr. Graham presented a paper on some of the Therapeutic Uses of Sapo Viridis, which gave rise to a discussion, wherein Drs. McGregor (Chatsworth), Ghent (Priceville), Macdonald (Toronto), and Cameron participated.

Dr. Woolverton, of Hamilton, then read his notes of a remarkable case of Hysteria, Hemorrhage from the Bowels, and mis-shapen dejecta, consisting of small spindle-shaped lumps, of long duration, and still under observation. Drs. Graham, Hamilton, and Cameron gave expression to their opinions thereon.

During the afternoon, invitations had been received from D. O'Reilly, of the General Hospital, and from the two Medical Schools in the city, to pay them a visit on the following day. After the discussion on Dr. Woolverton's paper, the Society adjourned to meet next morning at 10 o'clock, the committee meetings being called for an hour earlier.

At ten o'clock on Thursday morning the President was punctually in the chair.

The first order of business was the reading of the previous day's minutes by the Secretary, which were adopted. The President then read the names of the gentlemen nominated by him for the various temporary committees as follows, and to which the meeting unanimously assented, viz.:—

*Surgery, Anatomy, and Pathology.*—Drs. Malloch, Hamilton; Grasett, Toronto; Groves, Fergus; Stewart, Brucefield; Bridgland, Bracebridge; Powell, Edgar, and Winskill, Brantford.

*Medicine, Materia Medica, and Physiology.*—Drs. Fulton, Sheard, Cameron, Toronto; Herod, Guelph; Campbell, Seaforth; Worthington, Clinton; and Tucker, Orono.

*Obstetrics, Gynaecology and Jurisprudence.*—Drs. U. Ogden, Temple, Toronto; Tye, Tamesville; Brock, Guelph; Bowlby, Berlin; Keating, Guelph; and Farrell, Norwich.

*Ophthalmology and Otolaryngology.*—Drs. Roseburgh, Palmer, Ryerson, Toronto; Walker, Dundas; Kittson, Hamilton; and Bonnar.

*Necrology.*—Drs. Riddel, Toronto; Curry, Rockwood; Bascom, Uxbridge; Ghent, Priceville; Knight, Tamworth; and Osborn, Hartford.

*Audit Committee.*—Drs. Lett, Barrick, G. Wright, Toronto; Harrison, Selkirk; Gillies, Teeswater; and Webb, Waterloo.

*Papers and Business.*—Drs. McCulloch, Toronto; Mullin, Hamilton; Sloan, Blyth; Carney, Windsor; McGill, Oshawa; Harris, Brantford; Worthington, Clinton; and Day, Trenton.

*Arrangements.*—Drs. Fulton, Buchan, James Ross, sen., A. A. McDonald, Toronto.

The reading of papers being the next order of business, Dr. Canniff read a very interesting one on a case of obscure brain disease, giving its history, and presented the patient for examination before the association, many of those present taking part in the discussion, including Drs. Workman, McFarlane, Oldright, Cameron, Teskey, and Temple.

The Secretary then stated that Dr. Harrison, of Fergus, had a case which he wished to present, but as the patient had to return to his

home by the afternoon train it was necessary that the case should be considered at once.

Dr. Harrison was then called, and said that he hardly knew what name to designate the disease by, but for want of a better would call it Elephantiasis. The patient, however, was there for examination, and he would be glad to hear their opinions.

Drs. Graham and Sheard described others of a similar nature which they had observed.

Drs. Cameron, Teskey, Hamilton; Temple, Oldright, Riddel, and Osler followed, expressing their views.

Dr. Roseburgh (Toronto), exhibited a patient suffering from Mastoid Abscess, resulting from the employment of the nasal douche. *Vide* page 126.

Letters of regret at unavoidable absence were, then read from Drs. Burt (Paris), Christoe (Flesherton), McCargow (Caledonia), W. S. Scott (Southampton), and others.

The meeting of the Committee on Legislation for the purpose of organization was announced for 2 p.m., and an adjournment then took place until that hour.

(To be continued.)

### Miscellaneous.

TO EVERY MAN HIS OWN.—Our brother of the *Louisville Medical News*, in his issue of June 4th, complains of our having attributed an article of his on "Capsules," to the *Cincinnati Medical News*-man. We are sorry if we have unwittingly ignored his proprietorship in the article in question, but if he will kindly refer to pages 261 and 262 of Dr. Thacker's Journal for April, he will there find our justification and herewith our apology.

#### PAINFUL HÆMORRHOIDS.—

R. Extr. Belladonnæ.....	ʒij
Iodoformi.....	ʒi
Plumbi Acetatis.....	ʒj
Vaselinæ.....	ʒj

Sig.:—Apply 3 or 4 times daily. The above will be found a most excellent application for painful or inflamed piles. The tumours should be bathed in cold water just before each application, and the bowels kept freely opened by a gentle purgative.—*Gaillard's Medical Journal*—*Medical Herald*.



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# THE Canadian Journal of Medical Science.

A MONTHLY JOURNAL OF MEDICAL SCIENCE, CRITICISM, AND NEWS.

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TORONTO, AUGUST, 1881.

## Original Communications.

### GRANULAR OPHTHALMIA WITH PANNUS, TREATED BY INOCULATION.

BY T. BULLER, M.D.,

Ophthalmic Surgeon to the Montreal General Hospital.

Notwithstanding the great advances made in Ophthalmology within the last half century, one of the commonest and most easily recognized diseases of the eye still remains a real opprobrium to the healing art.

Essentially chronic in its nature, granular ophthalmia at best runs a tedious and protracted course, but when corneal complications arise, and more especially when the condition known as trachomatous pannus, has become developed, the chances are the sufferer will become weary of himself, of the disease, and of his medical adviser, long before he reaches the end of his troubles. Although nature, perhaps assisted by art, may still, sometimes, achieve a final, though tardy victory, there remains a no inconsiderable proportion of these cases that bid defiance both to nature and to all the resources of the pharmacopœia.

These are the cases that come to the specialist, often in a state of blank despair, and with the sorrowful record of having been everywhere and tried everything without obtaining relief. Desponding and dejected to the last degree, they are willing to submit to any plan of treatment that holds out a reasonable hope of cure. For them a desperate remedy has no terror and they cheerfully take the chance, though the odds are represented as being strongly against success.

Fortunately there is one remedy that rarely fails when judiciously used, to effect a complete and permanent cure of this distressing condition, and the worst cases are, with the exceptions presently to be mentioned, the most suitable for its application. As a general rule it may be said the more complete and the longer the duration of the pannus, the better the results obtained by inoculation.

I have twice seen a moderate degree of pannus cured in both eyes by the unintentional auto-inoculation from gonorrhœal virus in consequence of the filthy practice, so common among the lowest classes, of using urine as a wash for sore eyes; probably some such observation first led to the employment of the mode of treatment known as inoculation.

It has been said that every case of granular ophthalmia might be treated and cured by inoculation, if some efficient means could be found to protect the cornea from the destructive effects of the resulting purulent ophthalmia, a desideratum not yet obtained and probably not attainable.

Inoculation then for the cure of granular ophthalmia is only justifiable when all the ordinary remedies have failed *and when the cornea is completely covered with blood-vessels*. If the latter are but thinly scattered over the surface, or if any part of the cornea is clear the danger is considerable but if so dense as to hide the colour of the iris and pupil, the procedure is a safe and certain cure excepting in feeble and strumous subjects or where the general health is very much deteriorated. Under these circumstances, I believe the resulting purulent ophthalmia is more likely to be of a virulent type and the resisting powers of the

cornea will very likely not be sufficiently great to withstand the tendency to ulceration.

Unfortunately these are just the sort of cases in which granular ophthalmia is most likely to be associated with an inveterate pannus, and the temptation to make use of some radical means of cure is the strongest. To ensure success then, no little discrimination is required in the choice of cases, as well as in the selection of pus used for exciting the necessary inflammation. I have little or nothing to add to the experience of earlier writers on this subject.

I have never used urethral pus for this purpose of inoculation. The objections to its employment are of too formidable a character to be set aside. I have sometimes employed the pus from eyes previously inoculated though unwittingly, for I greatly prefer that obtained from the eyes of infants suffering from an ophthalmia neonatorum that has lasted several weeks, and not caused any corneal complications, the pus at this stage of the disease, usually being pale, and of a somewhat creamy consistence. Yellow or greenish yellow pus is too virulent and should not be employed.

It is held by some authorities that the fact of one eye being healthy is an absolute contra indication to inoculation of the other diseased eye. In these cases I have always protected the healthy eye by means of my watch-glass protector and have not as yet had any cause to regret the risk. When the danger is explained to these patients, I found them most assiduous in keeping the little apparatus properly adjusted, and under these circumstances infection of the healthy eye is almost an impossibility. The protector seldom requires to be worn for more than four or five weeks, and whilst in use the patient is perfectly well able to help himself, which, of course, he could not do if the healthy eye were hermetically sealed up in the manner commonly recommended.

A pannus condition, even of one eye, is usually sufficiently distressing to keep the sufferer in idleness most of the time, and, therefore, the necessity of effecting a cure is almost as great as when both eyes are involved.

I have notes of nineteen eyes inoculated during the past four years without going into the details of each case. The following re-

marks are intended to give an idea of the general results:—

*Group I.*—In six cases only one eye was affected, of these four made a perfect recovery and regained excellent vision with the inoculated eye. In the two remaining, ulceration of the cornea occurred resulting in a small leucoma adhærens in the affected eye, with a good prospect of some useful vision after an iridectomy had been done. The other of these two cases was a delicate boy, ten years of age, with ozæna and an inveterate pannus of three years duration. An intense purulent ophthalmitis of a diphtheritic character, set in four days after inoculation and a rather large perforating ulcer of the cornea ensued. An increasing prolapse of iris resisting other means employed to check its progress necessitated removal of the lens. Since which the cornea has recovered to a surprising extent, and there seems a prospect that some vision may be obtained by an artificial pupil. The case is still under observation. It is worthy of note that a peritomy had been done on this eye some nine months previously; as far as it goes, the fact is opposed to the reputed protective influence of this procedure in cases of otherwise doubtful fitness for inoculation.

*Group II.*—In three cases, only one eye was considered fit for inoculation, the other being duly protected from infection just as the healthy eye had been in the first six cases. Of the second group one eye recovered without complication; one with perforating central ulcer of the cornea, but no prolapse of iris; one with perforating ulcer and prolapse of iris which required an iridectomy to check the tendency to corneal staphyloma. Both the latter cases are still under observation and the final result not yet determined.

*Group III.*—In five cases both eyes were inoculated. In one both at the same time; one after five days, with pus from the other eye; one after seven days, also from the other eye; two after ten days, from the other eye.

Of these five cases three recovered without any complication and obtained good vision with each eye. In the remaining two perforating ulcer occurred in the cornea of the right eye. In one of these there was prolapse of iris which yielded to the usual remedies for this condition



but a month after the patient had returned home, secondary glaucoma came on and the patient disregarding strict injunctions to present himself at once if any trouble occurred, finally came with a large staphylomatous formation at the seat of prolapse, and vision reduced to perception of light. An iridectomy greatly reduced the staphyloma and restored vision so far that he was able to count figures at three feet distance. The other imperfect result was in a feeble woman about forty-five years of age. A small perforating ulcer occurred in the centre of the right cornea three weeks after inoculation. The ulcer healed and vision began to improve after an iridectomy downwards. The final result will probably be satisfactory, since a considerable improvement in vision has taken place already and the inoculation was only done eleven weeks ago.

To sum up the result of the nineteen eyes inoculated, thirteen recovered perfectly without any complication. In six perforating ulcer of the cornea occurred. The ulcer being nearly central, they all required or will require an iridectomy for artificial pupil. In only one instance, the youngest of the list, can the eye be said to have been lost for visual purposes, but even here the cure of the disease and the relief given by removal of the constant irritation is a real boon to the patient, as he will be able to use the healthy eye without discomfort.

A somewhat significant fact was the occurrence of ulceration of the cornea in the three youngest patients. In one of them the eye seemed in every respect most favourable for inoculation. If any conclusion can be based upon this limited observation, it is that inoculation in early life, or before puberty, is peculiarly hazardous. In adults this method of treatment is, *in suitable cases*, perfectly satisfactory and cannot be too highly recommended. I could not make up my mind to follow the advice of authorities on this subject and always leave the eye entirely without treatment, excepting occasional washing with simple water after the inoculation.

Whenever the case was uncomplicated, I adopted this plan with hesitation, but so soon as I found ulceration of the cornea I always treated the purulent ophthalmia with a view to

lessening its intensity and to arresting the ulcerative process in the cornea, and I feel satisfied that by so doing the eye was more than once rescued from impending destruction

### A CASE OF COMPLETE RUPTURE OF THE PERINEUM WHICH UNITED SPONTANEOUSLY.

BY J. H. RADFORD, M.D., GALT.

I have thought the case cited below well worthy of record, because, first, it seems to me to go far to decide the advisability of immediate operation in such circumstances, and second, the method of treatment adopted, although not distinctly recommended by Thomas, resulted so satisfactorily that it may be considered well worthy of trial in similar cases.

In regard to the first point it is well known to all students of this department that there is a wide diversity of opinion as to the time for operation, some urging immediate action, some advising delay for a few days, while others advise delay until the effects of parturition are over.

To the first class belong Baker-Brown, Scanzoni, and Thomas; to the second, belong Velpeau; and to the third, Nélaton, and Verneuil.

I think, after due consideration of this case, the profession will strongly favour the first method of treatment, because if one out of twenty would succeed it would save a good deal of needless pain and suffering to such unfortunate victims.

Before entering into the details of the case I desire to call your attention to Dr. Thomas' remarks. He says that "when the rupture has been complete it has been asserted that spontaneous cure has taken place," but such reports need confirmation. He also mentions a case in which recovery was said to have taken place, but which, when examined thirty years after, showed the rupture still ununited.

The case is as follows:—Mrs. B——, aged 35, primipara, with a small pelvis.

On the 18th May, I was summoned to attend her as she was about to be confined. On my arrival I found her having pretty severe pains

which were coming on very regularly. I made an examination per vaginam and found a thin, soft, dilatable os, about the size of a crown piece. In the course of an hour I made another examination and found the os dilated to its full size, after which the pains began to diminish and continued to do so for about an hour. I then gave her an enema and a dose of ergot which did not have much influence over the uterus, so I gave another 3ss dose, which had a decided effect.

Pains came on and in spite of all my efforts to prevent rupture, by smearing with olive oil, dilating with fingers, supporting the perineum, and shoving up the head, it was torn through the sphincter ani. Case lasted ten hours.

Treatment—After washing the part thoroughly I put in two silver wire sutures and tied the knees together, placed her on her side in which position she was kept. I kept the bowels confined for ten days by morphia. Drew off water for the first week twice a day, after that time she made it while lying on her abdomen. The vagina was washed out twice a day with a carbolic solution.

On the tenth day I gave her an enema and broke up the feces with a pair of forceps. She then got an enema for the five following days. About the 13th day I removed the sutures and found good union. Have examined her twice since last time, about four weeks after the rupture took place. Diet consisted of beef-tea, chicken broth, and milk. No solid food whatever.

[If care be taken always to pass the sutures deeply, so as to restore the perineal body, we are satisfied the immediate operation will often prove successful as it did in the above case.—ED.]

Joseph Skoda, formerly Professor of Medicine in the University of Vienna, and the last link between the old Vienna School, as represented by Oppolzer, Rokitansky, and Hebra, and the present, died on the 13th June, last, after a lingering and painful illness, at the age of seventy-five. His chief work was on Auscultation and Percussion.

## HYOSCYAMINE.

BY C. K. CLARKE, M.D.,

Asylum for the Insane, Hamilton.

So much having been said in praise of hyoscyamine as a sedative we determined to try it in this asylum, a few months since.

Mack's crystalline, was the only preparation used, and the patients treated, were cases of acute, chronic, and recurrent mania.

Case 1—J. S., male, aged 57. Admitted November 12th, 1880. Came in labouring under an attack of acute mania, was extremely violent, boisterous, and difficult to manage. Became so unmanageable during the day that it was found necessary to restrain him.

November 13th.—There was no improvement in the condition of the patient. One-tenth grain of hyoscyamine dissolved in alcohol was ordered, and had a wonderful effect, quieting the patient down until the 15th November. Upon that day he again became unmanageable and one-fifth grain was prescribed. The patient kept under the influence of the drug four days, receiving each day one-fifth grain. He received the last dose on the 18th November, and from that date until the 30th November, when he left our charge, remained perfectly quiet and was apparently very well, although we did not consider him perfectly recovered. After leaving the asylum, he returned to his home, the old exciting influences upset him, and he was brought back in two weeks time, nearly in the same condition as when first admitted. One-fifth grain hyoscyamine was immediately prescribed and the dose repeated next day, when our patient again quieted down and remained quite well until March 30th, 1881, when he was discharged perfectly recovered. Is working regularly, and at present date is as well as ever.

Case 2—J. R., male, aged 17. His aunt was insane. Patient has frequent attacks of recurrent mania, and when under their influence is extremely troublesome and dangerous. His attacks are generally of three weeks' duration at the very least.

The patient having been excited for a week, one-tenth grain of hyoscyamine dissolved in alcohol was given, but produced no effect. This



was on the 13th November, 1880. Next morning the dose was increased to one-fifth grain, and in an hour the patient had quieted down and kept quiet until next day, when he became violent once more. He took one-fifth grain on the 15th and the same dose the day following, when it was not found necessary to prescribe any more of the drug, the patient having become perfectly quiet and manageable, remaining so until the next period of attack, some six weeks later. Again the hyoscyamine had the desired effect and cut the paroxysm short. These two cases are, perhaps, as typical as any we can enumerate. In the case of recurrent mania, chloral had often been tried, but beyond controlling the mania for the time being, did not seem to exert any beneficial effect, and did not shorten the duration of the attack. Hyoscyamine acts very speedily and the patient seems at first like one intoxicated. In a short time there is mild delirium, and if not watched the patient is apt to crawl about the floor and grasp at imaginary objects. In all the cases under our care where hyoscyamine was given, marked dilatation of the pupils resulted. The after effects are merely a little dryness of the mouth and difficulty in distinguishing objects owing to the dilatation of the pupils.

We have tried the drug in a fair number of cases and have come to the following conclusions in regard to it:

If any sedative is *really* required in the treatment of mania, hyoscyamine is the drug most applicable to the majority of cases.

It cannot be claimed to have any curative effect, but as a controlling agent is very valuable.

We believe it cuts short attacks of recurrent mania, and in many cases of acute mania will give much needed rest.

Not having any faith in the use of chloral in the treatment of acute mania we are glad to welcome hyoscyamine as a sedative which leaves such trivial after-effects.

Chloral seems to *lengthen* attacks of mania, hyoscyamine to shorten them.

There is at present one drawback in the use of this preparation, and that is the great cost of the article. The present price places it beyond reach for ordinary use. [Especially in public hospitals.—Ed.]

## Selections: Medicine.

### STERTOROUS BREATHING IN APOPLEXY AND THE MANAGEMENT OF THE APOPLECTIC STATE.

BY ROBERT BOWLES, M.D., FOLKESTONE.

In the investigation of the causes of stertorous breathing in apoplexy, I found that they were mechanical, and could at all times be so changed as to alter altogether the nature of a case, and often to make the difference of recovery or death; and, moreover, that the principles involved applied not only to apoplexy, but to many abnormal conditions allied to it. The subject having been now before the profession for twenty years, one is surprised to find how little attention appears to have been directed to it in our medical schools. Younger members of our profession to whom I have spoken, certainly do not realize its importance; and yet the value of a knowledge of it in the management of the apoplectic state is far greater than bleeding, blistering, calomel, crotonoil, and the rest.

The removal of the causes of stertor so immediately changes the aspect of a case, that the question of blood-letting is at once solved in the clearest and surest manner. The truth is, two separate conditions of the apoplectic state have been jumbled together and treated as one: the cerebral affection, and the condition of suffocation consequent upon it. Stertor, in one sense, is but a croup in the pharynx, or apoplexy *plus* suffocation, as croup is laryngitis *plus* suffocation. We feel it necessary to relieve croup by a serious operation; whereas stertor is left to itself, although it may be relieved by merely changing the position of the body.

On referring to the literature of the subject, I have been astonished to find how difficult it is to draw any conclusions from the descriptions of the disease, or the treatment to be adopted. Authors are not agreed; and one of our most distinguished neurologists, in an article on Apoplexy, in a recent important work on medicine, with infinite labour, appears to arrive at the conclusion that, in apoplexy, we can know nothing, we can foretell nothing, and we can do

nothing. This confusion arises in great measure from the stertorous breathing, converting all cases in which it is present into cases of apoplexy *plus* suffocation.

It is agreed that there are cases of apoplexy in which the face is pale, and the pulse small, and in which bleeding is not to be thought of, and also that there are cases in which stertor is not present; but I cannot, with all my diligence, find out from any works, that have been open to me, whether these two conditions, that is, the pale face, and the absence of stertor, were co-existent. There are no observations made by any author as to the position of the patient in the non-stertorous case.

Suffocation, added to grave mischief in the brain, must of necessity affect not merely the symptoms of progress of cases, but also their mortality. Those only who have observed the extraordinary change on the removal of suffocative stertorous breathing, can judge how the diagnosis and prognosis are affected by it, and, not less so, the treatment and morbid anatomy.

Most modern writers on apoplexy adopt the general views of Dr. Abercrombie, and naturally, from the broad division of cases into sthenic and asthenic, are disposed to bleed in the former, and to avoid it in the latter; whereas, if we look upon the hard slow pulse, as the result of the heart labouring to overcome an obstruction in the lungs (suffocation), we shall at once see that our first duty is to remove this obstruction, and thus simplify the case.

Heberden and Fothergill were opposed to bleeding in any case, and the latter has made some curious suggestions which pertain to the subject of this paper. He says that "even the hard, full, and irregular pulse, which seems imperatively to call for a free use of the lancet, is often an insufficient guide, since it may be that struggle which arises from an exertion of the *vires vite* to restore health." From what has already been said, you will readily guess that I should say, "this strong pulse arises from an exertion of the *vires vite* to overcome vascular obstruction caused by gradually increasing suffocation."

Niemeyer, more than others among recent authors, has attempted to be systematic, and to

clear away the confusion attached to apoplexy; but, like others, he fails, from not discriminating between the apoplexy and the suffocation. He believes that the shock and oppression of the apoplectic state arise from anæmia of the brain-substance, from sudden compression of the cerebral capillaries; this anæmia is always seen after death, and is shown during life by the very symptom which has always had a contrary interpretation—"a remarkable pulsation of the carotids." This, instead of being a sign of increased pressure of blood to the head, really indicates that the flow of blood into the skull is obstructed "by the space", he says, "in the skull being affected, so as to prevent the escape of blood from the afferent vessels;" throwing the blood back, as it were, into the carotids.

As a consequence of this view, under the head of treatment, he says, "it is evident that, under some circumstances, venesection is a very useful remedy; under others, it is very injurious, and the indications for it may be very exactly given. In order that as much arterial blood as possible may enter the brain, we must try to facilitate the escape of venous blood, without however, diminishing the propelling power too much" (what a plea is this for removing suffocation); then, he continues, "if the impulse of the heart be strong, and its sounds loud; if the pulse be regular, and no signs of commencing cedema of the lungs exist, we should bleed without delay. If on the contrary, the heart's impulse be weak, the pulse irregular, and the rattling in the trachea has already begun, we may be almost certain that bleeding would only do harm, since the action of the heart, which is always weakened, would be still more impaired, and the amount of arterial blood going to the brain would thus be still more decreased."

The simple illustration of some of my early cases will best illustrate what usually happens in a case of apoplexy, and how it may best be managed.

CASE.—In October, 1863, Miss B. was seized with apoplexy. On my arrival there was a partial return to consciousness, and the left side was found to be paralysed; there was pharyngeal stertor when in the recumbent pos-



ture, and she appeared uneasy when placed on her right side ; she was, therefore, placed on her left when the stertor ceased. A blister was applied to the nape of the neck, and she remained in this position for nine days. She was now better and spoke to me. Fearing a bedsore, I desired the nurse to change her position, (by turning her from her left to her right side. Soon after this was done, she was distressed for breath, and the countenance became livid. On my arrival, I found the difficulty of breathing gradually increasing ; the blistered surface, as well as the ear upon which she had lain, of a dark purple hue ; and the pulse, which had before been weak and irregular, full and bounding. There were large mucous *rales* over the whole chest ; she was quite unconscious, and death from suffocation was imminent.

Finding that these symptoms supervened upon the change of position, I had her placed upon her left side, and immediately the pulse sank, the mucous stertor ceased, the breathing was relieved, the lividity of countenance passed away, and the blistered surface, which had been almost black, resumed a bright cherry-red color. This additional shock, however, proved too much for her, and she died the same day, peaceful and conscious.

The salient points of this interesting case are these : 1. Pharyngeal stertor ceased when the patient was placed on her side ; 2. There was a slow but gradual improvement subsequent to this ; 3. Mucous stertor and imminent death supervened when she was changed to the opposite side ; 4. Instant relief followed on resuming her original position ; 5. A return to consciousness was coincident with the cessation of stertor ; in other words, with the removal of the respiratory difficulty.

On a careful examination of the chest after she became quiet, I found all *rales* slowly fade away from the right side, or that which was uppermost, and the natural breathing return ; but the left lung, which had been dependent throughout, was dull on percussion, and deficient in respiratory murmur.

The explanation now became clear, viz., that the dependent lung had become filled with some mucous fluid, and that, on changing the side, the fluid by gravitation was finding its

way across the trachea to the opposite lung ; but, in doing so, it had been churned to foam by the ingoing air, giving rise to mucous stertor ; and this foam, by filling up the larger bronchial tubes, was quickly causing suffocation, with all its usual results.

As a point of management, then, in cases of apoplexy, it would appear necessary to keep the patient on one side, and not to change it ; but which should this be ? Healthy people, when lying on the side, breath chiefly with that side which is uppermost, for the intercostal and other thoracic muscles of the lower side are fixed between the weight of the body and the bed, and the breathing of this side is almost entirely diaphragmatic. It must be remembered, too, that in placing the paralysed side downwards, the injured side of the brain is upwards, and, therefore, relieved from hypostatic congestion, a condition always liable to occur when an injured part remains dependent.

In my original paper, in the *Transactions* of the Royal Medical and Chirurgical Society, three varieties of stertor were defined :

1. *Palatine Stertor*, when the air, in rushing through the nose or mouth, causes a vibration of the soft palate.

2. *Pharyngeal Stertor*, when the air passes through the narrowed interval between the base of the tongue and the posterior wall of the pharynx.

3. *Mucous Stertor*, depending upon air bubbling through mucous in the larger air-tubes.

Besides these, there is occasionally, but only very occasionally, what may be called a *laryngeal stertor*, heard most commonly during the inhalation of chloroform, which has been pointed out by Professor Lister. Whether this arises from a spasm of the glottis, or from paralysis of some of the laryngeal muscles, I am not prepared to say. There is, however, a *nasal stertor* which belongs more to the apoplectic state, and, as far as my experience goes, is often a symptom of the gravest kind. It arises from paralysis of the nerves supplying the elevators and dilators of the *alæ nasi* ; so that the ingoing air, as in sniffing, draws the *alæ nasi* towards the septum, and sometimes causes a serious obstruction to the breathing, and certainly hastens death, as well as needless-

ly distresses the bystanding and sorrowing relatives.

CASE II.—A lady, sixty years of age, fell head-foremost down stairs, and was taken up unconscious. She had complained much of head-discomfort in the morning, but nevertheless had been out for a short walk. The weather was thundery. On my arrival, immediately after the fall, there was considerable ecchymosis at the outer angle of the left orbit; but there was no bleeding from the ears, nose or mouth; nor was there any extravasation between the ocular conjunctivæ. I found her wholly unconscious, breathing stertorously, and vomiting. The right pupil was dilated and fixed; the left very sluggish. When she was turned on her side the stertor ceased; the aspect of the face became almost natural; and she moved her left arm and leg, and remained like a person quietly asleep for twenty-four hours. At this time, *nasal* stertor commenced, and gradually increased in intensity; and *pari passu*, the face became congested and turgid, the veins of the temple stood out in bold relief, and in about an hour she died.

Dr. Monckton saw this case with me in consultation; and I was able to demonstrate to him how stertor and its consequences instantly recommenced in this poor lady's case when she was placed in the supine position, and also how easily nasal stertor could be removed either by pressing the tip of the nose upwards, or by dilating the nares with the handle of a salt-spoon.

There is yet one other form—the puffing out and flapping of the cheeks and lips—which may be fairly dignified with the title of *buccal* stertor. Now, although this last does not give rise to any respiratory difficulty, it is nevertheless, like nasal stertor, of importance in prognosis, and useful for purposes of definition. Like nasal stertor, it is dependent on paralysis of the portio dura, and therefore, indicates the approach of the intracranial mischief towards that part of the brain which governs the functions of organic life, or (which is a very important alternative) that both it and nasal stertor may arise simply from venous engorgement at the base of the brain, in consequence of the suffocative stertors damming the jugulars.

Authors have always looked upon this symptom as an extremely dangerous one; and so no doubt it is, in the combined conditions of apoplexy and suffocation; but, as I have observed both it and nasal stertor, in a modified degree, in the snoring sleeper, and as cases of suffocative apoplexy, in which it has been most marked, sometimes make a rapid recovery, I withhold my opinion for the present.

Indeed, it is almost impossible, from the writings of the past, to arrive at any conclusion as to the value of any symptom of apoplexy. We must now observe from a new point of view (apoplexy without suffocation), and draw our conclusions in the future. The following short case is a happy illustration of some of these remarks. I am indebted to Dr. Lewis, of Folkestone, for the notes.

CASE III.—A lady, sixty-seven years of age, was found in her bed in an apoplectic condition. There was total loss of consciousness; the pupils were of about the usual size, but fixed; there was slight reflex action on touching the eyeball, and an occasional involuntary movement of the arms. The face was turgid, and there was both *pharyngeal* and *buccal* stertor. On being placed on her side, the stertor instantly ceased, and she gradually improved. In twelve hours, she had perfectly recovered consciousness; the respiration was normal; the face very pale, and the pulse quick and feeble; and there was no paralysis.

Surely no case could have looked more unpromising than this, when the age is taken into consideration.

*Nasal* stertor is unaffected by the position of the body, but may always be relieved by mechanical means.

*Palatine* stertor is usually of the least consequence; *i. e.*, it obstructs the breathing only very partially, and cannot always be removed by changing the position of the body. It is affected by the size of the tongue, the length of the uvula, the position of the chin, and other incidental conditions, all of which may be obviated if the obstruction to the breathing be sufficient to render it worth the doing.

*Pharyngeal* stertor is the most common, in severe cases of apoplexy, when patients are recumbent. This may always be obviated by



properly arranging the position of the patient; allowing the paralysed mass—the tongue—to gravitate to one side, rather than against the back of the pharynx.

*Mucous stertor*, when unconnected with lung-engorgement, the consequence of suffocation from stertor, only occurs in very serious cases, depending upon interference with the nutritive processes of the lung-tissues—probably arising from accident to, or pressure upon, the medulla oblongata. This can always be satisfactorily removed by proper attention to the position of the body.

These principles apply not merely to apoplexy but also to all apoplectic conditions. Especially I would mention drowning, epilepsy, convulsions in children, meningitis with effusion, death-rattles, fracture of the skull, concussion, bronchitis, (especially that of old people) sudden cedema of the lungs, large hæmorrhage from the lungs, great exhaustion, chloroform-poisoning, drunkenness, opium-poisoning, and all conditions in which mucous or fluid exists in the lungs; and also all conditions allied to the apoplectic, whether there be mucous or not.

I have seen and treated all these conditions, and invariably with a similar result—an unfailling relief to the distressing symptoms and their consequences; and in many instances, both in my own as well as in the practice of my friends, ultimate recovery has occurred in cases which must, we believe, have terminated fatally if the obstruction to the breathing had been allowed to continue unrelieved.—*The British Medical Journal*.

#### CHOLERA INFANTUM.

R	Argenti nitrat. ....	gr. j.
	Acid. nitric. dil. ....	m viij.
	Tinct. opii deodorat. ....	m viij.
	Mucil. acaciæ ....	3 ss.
	Syr. simplicis ....	3 ss.
	Aq. cinnamomi. ....	3 j.

M. Sig.—A teaspoonful every three, four, or six hours to a child one year old.—Bartholow.

This combination is remarkably beneficial after the acute symptoms have subsided.—*Michigan Medical News*.

#### VARIETIES OF ACUTE LOBAR PNEUMONIA.

M. DIEULAFOY.

If lobar pneumonia always presented itself to you with the frankly acute character, it is very certain that errors in diagnosis would not be produced, and the disease could never be mistaken.

Unfortunately, it is not so in practice, and this phlegmasia, so frank, and so clear, which I have just described to you, affects certain varieties which you ought to know.

We can immediately arrange these varieties in three great classes which we will afterwards subdivide.

Varieties according to the *situation* of the phlegmasia, according to the *age* of the subject, and lastly, according to the medical constitution of the period.

To the first of these varieties belong the *central* pneumonias, double pneumonias, and those of the apex. In these different forms you will find all the phases of lobar pneumonia frankly acute: the anatomical lesions will be quite the same: but the patient not re-acting in the same manner, will offer to you a train of symptoms which might deceive you if you were not forewarned.

In *central* pneumonia, the patient will present himself to us saying that he has had a single internal chill with a consecutive stitch in the side. You will observe a very pronounced dyspnoea, the pulse is large, the countenance empurpled: everything confirms you in the idea of a pneumonia, and as your patient has been suffering for from twenty-four to thirty-six hours, you auscultate him with the certainty of finding crepitant râles, but you hear nothing: you make your patient cough, always with the same result. You ask to see the sputa, there is none, or it has been thrown away. In presence of these facts, you are truly perplexed. The onset is certainly that of pneumonia, the temperature is equally conformable to what you know, 39 degrees (102.2° F.), but there are no crepitant râles! Are you to conclude from this that there is no pneumonia?

No, wait until the morrow, and you will have the rusty sputa, but it will often be only on the fourth day that you will perceive the

crepitant râles and the tubal souffle. You were in presence of a central pneumonia which took four days in reaching the periphery of the lung. In these cases the diagnosis ought to be made at once, for in no other disease will you find a unique chill followed by pain in the side with a temperature of  $39^{\circ}$  ( $102.2^{\circ}$  F.), and  $40^{\circ}$  ( $104^{\circ}$  F.) at the second and third day.

Another case may present itself: it is that in which a patient, already attacked with unilateral pneumonia, will be taken with double pneumonia towards the fifth or sixth day of his illness. Let us suppose, for example, that we have a left pneumonia. All has proceeded regularly. Your patient is better, the temperature is falling, and nothing causes you to foresee a complication. The next day, that is, on the fifth, you take the temperature, and you are surprised at finding it still  $39^{\circ}$ ,  $39.5^{\circ}$  ( $102.2^{\circ}$ — $103.1^{\circ}$  F.) You question the patient, who says he is getting better. There is no quickening of the pulse, nor increase of cough, nor pain in the side, the dyspnoea is not more pronounced. On auscultation you find always your crepitant râles and tubal souffle. In a word, the patient is better, the temperature alone does not satisfy you.

The next day, not only the thermometer still marks  $39^{\circ}$  ( $102.2^{\circ}$  F.) but the evening before it had marked  $39.8^{\circ}$  ( $103.6^{\circ}$  F.), and yet the patient feels always just as well. Be not deceived by what he tells you, seek—auscultate on the right, and most often you will find there the explanation of the maintenance of the temperature at  $39^{\circ}$  ( $102.2^{\circ}$  F.) A *second pneumonia* (mark that I do not say secondary) will have declared itself. A single fact may put you on the track of this second pneumonia; put the same thermometer in the left axilla, the side in which existed the first pneumonia, then in the right axilla; if the two temperatures are sensibly equal, there will be a double pneumonia. It will happen even that the first pneumonia being on the way to resolution when the other begins, the temperature will be less elevated on the side of the first, than on the side of the second. These second pneumonias, which are shown in about one-fifth of the cases, are not grave, and in no way hinder the re-

covery of the patient: they are rather hyperæmic than frankly phlegmasic pneumonias.

A third variety of pneumonia may present itself, as to its situation: it is pneumonia of the apex, whose prognosis is so grave that Cruveilhier said it was always mortal, and he is right, in the majority of cases. Not, as some authors have pretended, that this gravity is due to the situation itself of the pneumonia, but to the constitution of the individuals in whom it declares itself. Professor Peter has conclusively demonstrated that, if pneumonia of the apex is dreaded, fatal, and often proceeds to suppuration, this is due to the individuals themselves, who are alcoholics, cachectics, debilitated by one cause or another, and in whom pneumonia is localized by preference in the apex of the lung: such is the veritable cause of its gravity, without being obliged to accuse the situation. In these patients the pain in the side will sometimes be wanting, the initial chill will be less marked, the expectoration itself may not be characteristic, and lastly, on auscultation, you will not find crepitant râles, if you have not in mind this variety of pneumonia. To discover the pneumonia centre, you ought to separate the arm from the trunk of the patient and apply the ear to the upper portion of the axillary space. It is there only that you will perceive the crepitant râles which will allow you to diagnose a pneumonia of the apex.

In addition to these varieties pertaining to the seat of the pneumonia, there exist others relative to the *age*. We will pass over pneumonia of the adult which we know, to speak only of that of the child, and of the aged.

Of the child, I will say only a word, for in it the disease is very rare, and when it is present it is without gravity; the pneumonia of the child is lobular pneumonia, of which I have spoken to you in my preceding lectures, and of which you know all the gravity.

Acute lobar pneumonia is very rare and benign in the child, it is unfortunately not the same in the aged in whom it is frequent, and takes a peculiarly grave character, which made Cruveilhier say that one-fourth at least of the aged died of pneumonia. How will you make your diagnosis? Here you are in the presence



of an old man who during the day was well; in the evening he was taken with *malaise* and vomited his dinner, the night has been bad.

You find that the tongue is dry, the eye brilliant, the cheeks red, and if you take the temperature you find at the maximum 39° (102.2° F.) In the presence of such symptoms can you recognize an onset of pneumonia? Your patient has not been cold, he has had neither chill nor pain in the side, and yet, if you auscultate, you will find, in place of the crepitant râles, dry and fine of the adult, large crepitant râles of return—humid râles. There is a pneumonia, and a grave one, and one to which the patient most often will succumb at the end of a few days.

We are very far from finding that *ensemble* of symptoms so clear and so characteristic, that I described to you in the adult. Remember the old man was not chilled, or at least had but a slight chill; in him the re-action is almost *nil*; pain does not exist; expectoration does not take place, for the ag-d expectorate with difficulty, and not expectorating, death takes place by suffocation.

Retain this then; every time that you find an old man, taken suddenly with *malaise*, having the cheeks red, the eye brilliant, and the temperature high, practice auscultation, and you will find the signs of a pneumonia, which though not provoking any suffering, is none the less of the highest gravity.

It remains for me to speak to you of certain varieties of pneumonia which are difficult to describe, for they submit to the influence of the medical constitution of the period, and that of each particular individual. We have seen how we may arrive at recognizing the varieties of pneumonia according to their situation and the age of the subject; but what I cannot trace for you here, is the form that these pneumonias will take according to the condition of the patient. You all know, to cite only one example, that in alcoholics, this disease takes the ataxic character, that we see subdelirium seize upon these individuals and that death is most often their termination.

Each individual will re-act according to his own constitution, and the disease will take

such, or such a character in relation with that constitution itself.

But, besides the patient, there is what is called the medical constitution of the period. You all know that there exist certain periods during which diseases affect a strange form. The symptoms are not those that we ordinarily meet with, there are certain years in which all diseases, smallpox, typhoid fever, or pneumonia, have a tendency to take the bilious, adynamic, or ataxic form, without our knowing why. You have a patient suffering from acute lobar pneumonia, all goes well for a certain time; then without anything to justify the change, your pneumonia becomes bilious, and the patient succumbs where he should have recovered. Why? We do not know, we can only state the fact. To get an account of the influence of the medical constitution upon the prevalent diseases, I advise you to read the remarkable work of Stoll on the medical constitution of 1775 and 1776, and the study of Chauffard on the medical constitution of 1862, in the *Bulletin de la Société Médicale des Hôpitaux*, 1863.—*Gaz. des Hôpitaux*.

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TREATMENT OF FREQUENTLY-RECURRING ERYSIPELAS OF THE FACE.—This affection is very annoying to the patient, for, in spite of every precaution, it will recur again and again. If any cause can be discovered, such as bad drainage, it should at once be remedied; but, whatever other hygienic or medical treatment be employed, some local application is generally necessary. All these applications are either disfiguring or disagreeable, or totally inefficient. For many years, my father and I have used, with entire success, a strong solution of tannin (four to eight grains to the drachm of spirits of wine and water.) This application, which is not disagreeable to the patient, should be painted over the parts affected with a soft brush every two or three hours, and allowed to dry, the patient being careful to keep the face from the fire. If there be a tendency to frequently recurring erysipelas, it is well to keep the tannin at hand, as it will always arrest a threatened attack.—JAMES BRAITHWAITE, M.D., in *British Medical Journal*.

## SYPHILITIC AFFECTIONS OF THE LUNG.

In a paper lately published in the *Giornale Italiano delle Malattie Veneree e della Pelle*, Professor Gamberini, of Bologna, enters at some length into the subject of pulmonary syphilis. Besides relating two cases of his own, which were judged to be instances of early syphilitic affection of the lung, the author quotes fully a number of cases recently reported by other observers.

The following are the general conclusions at which Gamberini has arrived after a careful study of his own cases and those of others. The existence of a simple inflammatory syphilitic pneumonia may be admitted, but it is not yet conclusively proved. The occurrence of a gummy form of disease of the lung is established beyond doubt. True pulmonary tuberculosis may be associated with syphilis, but it preserves always its own pathological characters. To distinguish between the syphilitic and the tubercular forms of lung-affection, the author proposes for the former the title of "consumptive pulmonary syphilis." The influence of specific treatment is, at the present time, the best therapeutic means of diagnosis between tubercular and syphilitic diseases of the lung. The author agrees with Schnitzler that pulmonary disease as a consequence of late general syphilis, or even of acute secondary syphilis, is not a rare occurrence. Laryngeal lesions often precede or accompany syphilitic pulmonary affections. This has been proved by the observations of Schnitzler, who, indeed, affirms that the diagnosis of syphilitic lung-disease may be made by means of the laryngoscope alone. The symptoms of syphilis of the lung are generally those of pneumonic phthisis, from which, during life, there may be no certain means of distinguishing it; even after death, the distinction cannot always be made between gumma and tubercle, especially when the gummy nodules are in a state of caseation, or are infiltrated. It must be noted, that syphiloma most usually spares the apex, whereas tubercle most frequently attacks that portion of the lung. This, however, is not constant, as has been shown by Fournier. The course of pulmonary syphilis

is usually slow and apyretic, which is not usually the case in tubercular phthisis. Syphilis, also, is accustomed to attack only one lung, and one part of the lung. This tendency to localisation is considered by the author to be a very important point in the diagnosis of pulmonary syphilis, whether the lung be attacked at an early or at a late stage of the disease.—*British Medical Journal*.

## OCULAR SYMPTOMS IN DIFFERENT DISEASES.

Dr. Gorecki, as stated in the *Glasgow Medical Journal*, has tabulated his views as follows:

Blepharoptosis, or the falling of the upper eyelid, indicates paralysis, complete or incomplete, of the third pair.

Lagophthalmos, or inability to close completely the palpebral fissure, is a sign of facial hemiplegia, idiopathic or a symptom of cerebral disease.

Strabismus occurring suddenly, and accompanied by diplopia, is most frequently the result of some cerebral affection.

Xanthelasma (a yellow lamina sometimes met with in the skin) of the eyelids, occurs in certain alterations of the liver.

Sub conjunctival ecchymoses are frequent in whooping cough, and may sometimes, at the beginning of the complaint, clear up a difficult diagnosis.

Redness of the conjunctiva, watering of the eye, etc., indicate in the child the outbreak of some eruptive fever, particularly measles. The prognosis is favorable if the tears come when the child cries, but fatal if the secretion of the tears is arrested.

Spots on the cornea are often the indication of a strumous constitution.

Dilatation of the pupil, or mydriasis, indicates excessive fatigue, the existence of intestinal worms, meningitis in the second stage, or a true amaurosis. The dilatation is most frequently connected with atrophy of the optic nerve. It is seen also during an attack of epilepsy, on coming out of chloroform, after belladonna poisoning, etc.

Unequal dilatation of the two pupils points to the onset of general progressive paralysis.



Contraction of the pupils is one of the early symptoms of *tabes dorsalis*. It is met with also at the beginning of meningitis, in opium poisoning, and in the first stage of chloral poisoning.

Deformation of the pupil, particularly after the injection of atropine, indicates an old iritis, in nine cases out of ten, of syphilitic origin, if not depending on some disease of the neighboring parts.

Cataract in subjects under say forty or fifty, is frequently of diabetic origin, and constitutes soft cataract.

Finally, the ophthalmoscope enables us to recognize the retinitis of albuminuria in Bright's disease, of simple polyuria, and sometimes in the case of women during pregnancy. Retinal hemorrhages, œdema of the retina, and embolism of its central artery, are sometimes met with in organic affections of the heart. Optic neuritis and perineuritis and atrophy of the disc are symptoms of syphilis, or of tumors in the neighborhood of the cerebellum or the *corpora quadrigemina*.—*Phil. Med. & Surg. Reporter*.

### ON HERPES FACIALIS.

The following extract is from a lecture by Dr. J. M. Finny, published in the *Medical Press and Circular* :—

*Herpes facialis*—a better name than *herpes labialis*—is met with most usually on the lips, at the muco-cutaneous juncture; but it occurs also on cheeks, ears, and nose. Though an accompaniment of an ordinary cold or dyspeptic attack, *herpes facialis* is present in pneumonia, cerebro-spinal, intermittent, and scarlet fevers. During the present session you have seen it in both scarlet fever and pneumonia, and you will recollect the different significance which may be attributed to it in these two diseases. In the latter, so usually do the patients who present it recover that some authorities consider it a most favorable prognostic; while in scarlet fever it is an omen of a severe type, in which nasal discharges, arthritic complications, and a prolonged fever may be expected. The late Dr. Stokes used to lay down, as a maxim worthy of note, that a vesi-

cular complication of fever was ever one of serious import.

The most extensive case of facial herpes I ever met with occurred in a patient, aged sixty-six, who was admitted to this hospital in 1879, for pneumonia, as the whole of his right cheek, extending from the zygomatic arch to the nose was one mass of herpetic clusters, which became confluent. He made a rapid and good recovery. Notwithstanding the frequency of the favorable issue of pneumonia attended by herpes, I would not have you lay too much stress upon the value attaching to this symptomatic rash, inasmuch as most cases of sthenic pneumonia have a tendency to recovery, and many cases in which herpetic rashes are absent do equally well.

The ordinary cases of facial herpes present no difficulties of diagnosis, but you should remember it may attack the mucous membrane of the mouth and palate. Should it be confined to these places, you may find some difficulty in recognizing the disease.

Within the last couple of months I came across a rather puzzling case of herpes, in consultation with Dr. Wm. Lane, in the person of a well-known clergyman of this city. The whole soft palate, uvula, and arches of the palate were studded with vesicles standing on a reddened base. At first sight scarlatina or diphtheritic inflammation passed through my mind; but the absence of the characteristics of those diseases, and the presence of a most copious vesicular eruption on the alæ and dorsum nasi, the upper lip, and the adjoining surfaces of the cheeks and chin, made the diagnosis easy.—*Phil. Med. & Surg. Reporter*.

DR. WARBURTON BEGGIE'S prescription for troublesome cough, with copious expectoration in Phthisis :—

R Liq. Morphine Hydrochlor.

Acid. Hydrocyanic. dil. āā m xvij.

Spts. Chloroform.

Acid. Nitric. dil. . . . . āā ʒj.

Glycerine. . . . . ʒij.

M Infus. Quassie. . . . . ʒij.

A sixth part to be taken three or four times a day.

In this mixture, Dr. Lauder Brunton says in

a letter to the *London Lancet*: "We find the sedatives, morphia, hydrocyanic acid, and chloroform, to lessen the excitability of the respiratory centres; we find glycerine, which will tend to retain the sedatives for a longer time in contact with the back of the throat, and will also act to some extent as a nutrient. We have combined with these nitric acid and quassia, which have so-called tonic action in the stomach." The nitric acid will diminish the pulmonary secretion and therefore expectoration; but on the other hand, when as under certain circumstances is the case, the cough is very troublesome with insufficient secretion and expectoration, potash has a marked effect in rendering the pulmonary secretion more fluid and abundant. This effect of potash is specially referred to by Dr. Andrew Clark.

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## Surgery.

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### IODOFORM IN SKIN DISEASES.

The idea of using iodoform in the treatment of skin-diseases other than those due to syphilis has occurred to others as well as to Dr. Balmanno Squire. For some time past, it has been employed at University College Hospital: first by my colleague Mr. Godlee, and subsequently by myself. He had used it, in combination with the oil of eucalyptus, in some cases of eczema, and in lupus after erosion; the formula most used being iodoform gr. x, oil of eucalyptus ʒss to ʒj, vaseline ʒj. I have used the iodoform without the eucalyptus with success in some cases of subacute eczema, mainly on the back of the hands and forearms; in suitable cases, the result was often very rapid. I have now a boy under my care with eczema of the head, in which there was a profuse sero-purulent discharge, which became offensive in a short time; to this, an ointment, with ten grains of iodoform to the ounce of lard, was applied, speedily removing all fœtor, and reducing the discharge to serous only. It was, however, rather too stimulating at this stage to be continued long. Its penetrating and disagreeable odour necessarily limits its employment, though the oil of eucalyptus partially obviates this, besides increasing the solubility of

the iodoform. It is slightly stimulant as well as antiseptic, and must, therefore, be restricted to cases requiring some stimulation. I can well believe that it would be efficacious in impetigo contagiosa, by destroying the micro-organism on which the inoculability of the disease probably depends; but the less unpleasant ammoniated mercury ointment will be preferred by most, as it is so very efficient.—*H. Radcliffe Crocker, M.D., 28 Welbeck Street, Physician to the Skin Department, University College Hospital.—British Medical Journal.*

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DEPILATION BY RESINOUS APPLICATION.—Dr. L. D. Bulkley, of New York, recommends the following formula and process for depilation in cases of favus:

Yellow wax.....	3 iij; 12 00 Gm.;
Shellac.....	3 iv; 16.00 "
Resin.....	3 vj; 24.00 "
Burgundy pitch...	3 x; 40.00 "
Gum dammar.....	3 x; 40.00 "

Melt them together and form into sticks from one-fourth to three-fourths inch in diameter, and two to three inches long. The hair having been cropped short, the stick is applied with a slight rotary or twisting motion, and after a few minutes removed by bending it sidewise, by which movement the hair adhering to it will be withdrawn. The hairs thus left on the stick are burned off. In ringworm of the scalp the disease renders the hairs so brittle that they will break before being pulled out, so that the method will not be applicable in this disease.

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Mr. John Croft has been elected to the recently instituted chair of Clinical Surgery in St. Thomas' Hospital, London. Dr. C. S. Roy of Cambridge, has succeeded to Dr. Greenfield, in the Brown Institution.

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The rare occurrence of the simultaneous occupancy of the Presidential chairs of the Royal Colleges of Physicians and Surgeons, by members of one hospital and school, was this year celebrated by a banquet given to Sir William Jenner, and Mr. Erichsen, by their colleagues at University College.



## Midwifery.

### RUPTURE OF THE PERINEUM.

THOS. A. ASHBY, BALTIMORE.

1. The question of "support and non-support" must be determined by the condition of the perineum.

2. An attempt to preserve the integrity of the perineum may, under some circumstances, be attended with greater injury to both mother and child than a rupture. The lesion of greatest consequence to both mother and child must be considered.

3. The forceps, if carefully used, are of great aid in preventing lacerations, and should be employed to assist in extending and delivering the head when the condition of the perineum strongly opposes or arrests its passage.

4. The administration of ergot before the head has been brought to bear upon the perineum may give rise to violent expulsive effort and force a rupture of this body.

5. Lacerations play an important part in the induction of bodily and mental disease, and should be recognized at the time of their occurrence with a view of determining the necessity for surgical closure.

6. Perineal lacerations, even when simple in character, ought, as a rule, to be closed by primary union.—*Maryland Medical Journal*.

### CHLORAL IN LABOUR.

Dr. Kane formulates the following propositions:

1. Chloral may be employed in normal labor for the purpose of blunting sensibility, quieting nervous and hysterical manifestations, shortening labor, and destroying pains.

2. In complicated labour it has three uses, *i. e.* (a) to relieve pain; (b) to hasten dilatation of the os uteri; and (c) to increase the force of the uterine contractions.

3. Chloral, even when pushed to the production of anæsthesia, does not destroy the force of the uterine contractions.

4. The alleged danger of post-partum hemorrhage has no foundation in fact.

5. In moderate doses it is never dangerous.

6. The slight delirium that sometimes occurs is ordinarily removed by a second dose and need cause no alarm.

7. It is rarely necessary to use more than 3j. in any one confinement.

8. It is best given by the rectum, in the form of enemata or suppositories.—*St. Louis Courier of Medicine*.

[Care should be taken that the chloral is pure.—Ed.]

## Correspondence.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

DEAR SIR,—The Ontario Medical Council in its mightiness has decided that the most "inexpensive method" of licensing homœopaths is to pitchfork them into a quasi-security by a farcical examination. In our profession "good men and true" strive to act up to the motto "Miseris succurrere disco;" but surely the member of the Council and his followers who advocated the "inexpensive method" have (unwittingly of course) misapplied the motto, and placed the would-be licensed in the place of those who may be tempted by the M. C. P. & S. O., to entrust their health to his *licensed treatment*.

Yours,

VACUUS VIATOR.

Messrs. Wm. Wood & Co., the well-known New York medical publishers, have issued a special edition of their catalogue, beautifully printed and elegantly bound in blue satin with gilt edges, containing in addition to a list of their works the daily programme of the International Medical Congress of 1881, and a number of blank pages designed for annotations and memoranda. A copy is presented to each delegate to the Congress.

Henry A. DeLom, of the Toronto and St. Thomas' Hospital, has passed the Primary Examination of the Royal College of Surgeons.

The Bill requiring New York and Brooklyn plumbers to be registered, and to subject all their work to the inspection of the City Health Board has become law.

## PRESIDENTIAL ADDRESS.

BY WM. CANNIFF, M.D., M.R.C.S. ENG.

Delivered before the CANADA MEDICAL ASSOCIATION, in Halifax, N.S., on 3rd August, 1881.

GENTLEMEN,—It is customary for the President at each annual meeting to deliver an address upon some topic which he may select, bearing upon the subject of medicine, or matters appertaining to the interests and welfare of the Canada Medical Association. I do not expect to bring to my task the ability and eloquence which characterized the address of last year with which we were favored by my distinguished predecessor, nor of any of the learned and prominent gentlemen who have graced the chair since the organization of the Association. But it is my duty to meet your expectations on the present occasion so far as may be in my power.

Before I proceed I wish to express my thanks for the honor the Association conferred upon me by placing me in the position I occupy to-day, an honor which I feel is greatly enhanced by the fact that I succeed one so eminently gifted, so universally esteemed, and in every way so worthy of the position. Of course, it makes it more difficult for me to follow one thus fitted for the duties of presiding officer; but trusting to your good nature and charity, I will at once proceed to the subject-matter of my address.

After some consideration, I decided, although it is somewhat a departure from the course hitherto pursued, to bring to the attention of the Association and the profession generally afresh the code of Medical Ethics which this Association adopted at its organization, hoping at the same time that the attention of the public might become engaged in a consideration of the mutual obligations and responsibilities resting upon the medical profession and the public at large. Perhaps I could not have done better than simply to have read the Code as it is found in the Transactions of the Association; but there are some facts, some points, and some considerations not referred to in the Code with which it may be desirable to deal. And I shall take the liberty of clothing some of the ideas contained in the Code in fresh language, although it may not possess the same lucidity and conciseness.

The Code of Medical Ethics of the Canada Medical Association consist of—

1. The duties of physicians to their patients, and the obligations of patients to their physicians.
2. The duties of physicians to each other, and to the profession at large.
3. The duties of the profession to the public, and the obligations of the public to the profession.

## THE DUTIES OF PHYSICIANS TO THEIR PATIENTS.

It is one of the first and almost continual difficulties met with by the medical practitioner in administering to the needs of his patients, to give only the necessary attention a case in practice requires, and secure the approbation of his client. On the one hand he wishes to bestow the requisite time and thought necessary to restore the patient or allay pain, as far as the resources of medical science will enable him. On the other hand, he is often fearful that his attention may be considered unnecessarily diligent or prolonged. It is, therefore, most necessary that the physician should be fully imbued with the responsibilities of his office, consider the necessities of the case, and then unhesitatingly devote such time and energy as he believes the case demands, regardless of any other consideration. At the same time it is not improper for him to exceed what he may think necessary should the patient wish to have extra attention.

When two or more cases simultaneously claim the attention of the physician, he is bound to give the most urgent his first consideration, irrespective of the position of the patient, unless relieved of responsibility by another practitioner.

The response of the physician to a professional call should always be prompt, notwithstanding the fact that he is too often summoned in unnecessary haste and put to great inconvenience, when he might safely have made the required call in his ordinary daily round of duties. Those who have had experience know full well that there are some thoughtless or selfish people who, when they have decided to call in the doctor, desire him to neglect every one else, and come at once with all possible speed, re-



gardless of his other duties and obligations, or his own convenience. But the physician who feels the duty he owes to those who confide in his care, will charitably make allowance for the natural anxiety which has culminated in his services being sought, and should betray no annoyance because he may have been called with unnecessary haste, and has had his arrangements for the day, perhaps, destroyed. At such times not only the sick, but the sick one's family, may not be quite responsible for their precipitate conduct.

Under all circumstances, the demeanour of the physician should be calm and his words tranquil. He must not be gloomy at any time but treat the case with a smile and all the quietness of manner it will permit. The physician should ever come into the sick chamber as a sunbeam, never as a thundercloud. Again, he ought to be natural in his manner. No two are alike, and every one has his peculiarities; and for one physician to try to pattern after another, is to detract from his self-reliance, and diminish his usefulness. I trust it is unnecessary for me to say to the members of the Canada Medical Association that it belongs exclusively to the charlatan to magnify the danger or nature of the disease he is called to treat, so that the recovery which will follow, perhaps would follow without treatment, may seem to betoken great skill on his part.

The most skillful and observant physician is often unable at first to determine the nature of the malady he has to contend with; but it is no disparagement in the minds of the ordinarily enlightened public to honestly state he is as yet unable to say positively what may be the matter.

Now and again we have to endure annoyance after expressing our opinion candidly at the bed-side, wishing to conceal nothing from the patient, by a member of the family, in an outer room, or at the gate, or, it may be, by a neighbour on the road, asking the question, "Now what is your opinion? I will not tell any one." But an ever-repeated reply, that you have already given your opinion to the patient, will in time educate the public that you do not tell two stories. Of course there are occasionally

cases when you cannot state fully your views in the presence of the patient; but it is a safe and proper rule to conceal nothing from him. He should know the worst as well as the best, especially when you think he is sick unto death. It is wrong to deceive, and a mistaken view that for him to learn and understand the danger, will militate against recovery. To allow one to approach the dark valley, ignorant of the terrible and solemn fact is, in my opinion, inexcusable. On this point I am somewhat at variance with what is laid down in the Code; but I have no hesitation in saying, from experience I believe that the course I have recommended can be pursued without discouraging the patient, depressing his spirits, increasing the danger, or hastening a fatal end. No doubt "the life of a sick person can be shortened, not only by the acts, but also by the words, or the manner of a physician," as stated in the Code; but the considerate physician can so blend a true statement of the case with every reasonable ground of hope that no additional element of danger will result.

The relationship between physician and patient is one of confidence and trust. Fidelity and honor as the custodian of secrets connected with the patient, are strictly to be observed. To betray such confidence, or in any way refer to him, so that even an injurious construction can be placed upon your words is a violation of confidence. Yet, at times, it may be difficult to observe so manifest a rule of duty. In illustration, permit me to refer to an instance in my own experience. Not very long ago while in professional attendance upon a respectable employee in a leading hotel I declined to answer all the questions of the manager as to the nature of the illness, (it was not a question of contagion) whereupon I received a threat of expulsion from the building.

Moreover, to quote the language of the code, "The obligation to secrecy extends beyond the period of professional services; no circumstance connected with the privacies of personal or domestic life, infirmities of disposition, or stain of character, observed during professional attendance, should ever be divulged by the physician, except when he is imperatively required to do so."

In seemingly hopeless cases you are required "not to abandon the patient. Your attendance may continue to be highly useful to the patient and comforting to the relations around him, even to the last period of a fatal malady, by alleviating pain and other symptoms, and by soothing mental anguish." While it is your duty to candidly state your opinion when you consider the case hopeless, you must remember, not merely the old adage, that "while there is life there is hope," but that in many cases the physician is mistaken in measuring the resources of the patient's constitution to resist and overcome disease, as well as the efficacy of his treatment. It is no infrequent occurrence to have a patient seemingly stricken with a fatal malady unexpectedly rally, perhaps for a time, perhaps to recover. I have repeatedly known the too conscientious physician superseded by the assumptious charlatan, or sectarian doctor, who reaped the benefit of the previous skilful treatment, in connection with the unsuspected power of nature to restore. It is only a few weeks since I was told by a doctor of divinity that one of the most distinguished specialists in the United States had been actually poisoning him by his treatment, and would soon have killed him if he had not been induced to go to a homœopathic establishment. Here, he affirmed, in less than forty-eight hours, he was rescued from the "current of death," and new life was infused into his system. From my knowledge of the history of the D.D., who I may say was never a patient of mine, and of the deserved reputation of the physician accused of poisoning him, I have no doubt the latter was the means of preserving his health and senses so far as he now possesses them.

*Consultations.*—The physician, old as well as young, should never object to or discourage consultations. In fact he should be the first to suggest one. Consultations are desirable when life seems to be in danger, or when the case is a protracted one and does not yield to treatment. The physician may feel satisfied that he quite understands the case, and how to treat it; but he must consider the wishes of those concerned and the natural solicitude of the family. Moreover, very often, it is a relief to

have another to share the responsibility. It need not be considered a reflection on the physician's skill to have a consultation, even with a junior. When a young practitioner, I remember a consultation with me was objected to on the ground that it would be bringing coals to Newcastle. At the same time, it must be said that a consultation may be, indeed, I fear often is, detrimental to the patient. Apart from the injurious effects the excitement may have upon the patient, it must be admitted that the consultation too often leads to a compromise, and the views of neither as to treatment are fully carried out, while the treatment of either might alone have proved successful. I read lately an extract from one of Bulwer's novels in which he defines a medical consultation as "a meeting of physicians in which the councillors agree with the attending physician, and change the treatment." It would be in many cases a more correct statement to say that the attending physician would probably have modified, or changed his treatment at that particular juncture in the case, if a consultation had not been held. When the attending physician suggests a consultation he is usually asked to name the person he would prefer; but it is often desirable to have one chosen by the patient. It is needless to say that in the event of the physician selecting a councillor he should obtain the services of one he deems best qualified to render him assistance in the management of the case. When the patient makes the choice, unless the one chosen be unqualified, the attending physician should unhesitatingly accept the proposal. But the physician will positively refuse to consult with one not belonging to the regular profession. It is no part of the physician's duty to his patient, in any case, to depart from this rule. A demand is sometimes made that the physician shall have in consultation one who gives to himself a specific name,—who belongs to some *pathic* school. The regular physician possessed of the honor which belongs to a learned profession, and imbued with the spirit of scientific medicine destests any distinctive appellation in addition to physician. The followers of a sectarian school delighting in the name of homœopath, have applied to the scientific physician



the term "allopath." But we recognize no such distinction. We profess to be simply scientific physicians and surgeons. Not long ago a great cry was raised by the public, especially in England, because when a great statesman was the patient, a member of our profession refused to degrade himself by consulting with a homœopath. Sir Wm. Jenner was censured unsparingly by the press because he would not violate his principles and meet Dr. Kidd. The reply to this unwarrantable attack upon our profession, by the *London Lancet*, sufficiently covers the ground, and is quite to the point. "There was nothing personal in this refusal. The course taken was that to which every practitioner of scientific medicine must have felt himself impelled. No grounds exist for consultation between the ordinary physician and the professor of a particular school. Medicine is not a science which admits of sectarian views. If two mariners, one of whom believed the earth to be a flat disc, while the other held the commonly-received hypothesis of its spheroidal form, were asked to act together in navigating the same ship on a voyage round the world, how could they co-operate? We do not wilfully refuse to meet homœopaths; we simply decline because it would be a grim farce and a practical imposition to do so. The result must be a failure of justice to the patient, which may jeopardise his prospect of recovery. The course which practitioners should pursue in an emergency of this kind is very clear." These views of the *Lancet*, a journal which represents the profession of England, are the views of the profession everywhere. We are not called upon to contend with homœopaths. We may believe them to be sincere in their profession; but we can have nothing in common with them.

Another duty of the physician to his patient is to give him judicious advice, when he has become convalescent, as to the future. This advice may refer not alone to his physical and mental well-being but also to his moral behaviour. Sometimes the sickness has been due to the faulty or vicious life hitherto led; and with the bed of sickness have come earnest resolutions to reform and lead a new life. In such cases happy the physician who can from

the fullness of his heart strengthen good purposes and give proper guidance. "A word spoken in due season how good is it!"

#### OBLIGATIONS OF PATIENTS TO THEIR PHYSICIANS.

The first and second paragraphs of our code are as follows: "The members of the Medical Profession, upon whom so many arduous duties are imposed, and who are required to make so many sacrifices of ease, comfort, and health for the welfare of mankind, have certainly a right to expect that patients should entertain a just sense of the duties which they owe to their medical attendants. The first duty of a patient is to select as his medical adviser one who has received a regular professional education. In no trade or occupation does mankind rely on the skill of an untaught artist; and in medicine, confessedly the most difficult and intricate of the sciences, the world ought not to suppose that knowledge is intuitive."

The patient or the guardian should deliberately select the physician, and having done so should not hastily, or without sufficient reason dismiss him, or call in another. There is a class of people who are continually trying a new doctor; some on account of a constitutional love of change, some because the new doctor is recommended by Mrs. Busybody, or Mr. Touter, or Miss Interested, and some again make a change to be in fashion. Others seek a change from mercenary motives, or because they do not care to attend to a long-standing, unpaid bill. To this class it is, perhaps, useless to speak about the ordinary principles of honor and decency.

There can be no doubt that a physician who has become acquainted with the peculiarities of the constitution of a person or family, has a much better prospect of treating him, or them successfully than one who has no such previous knowledge. Having made a selection there ought to be implicit trust on the part of the patient; and he should be candid and open in his communication. It is neither safe for the patient nor just to the physician to conceal anything of a physical, or mental nature which may bear any relation to his disorder. But while the patient should state everything which may aid the physician in the discharge of his duties, he

must not make him the repository of extraneous secrets, nor should he take up the physician's time in talking about irrelevant subjects. The physician is not a talebearer and dislikes to hear gossip. At least such should be his character.

Too frequently there is a disposition on the part of the patient to delay in applying to the physician. Of course, no one would care to incur unnecessary expense; but a great risk is incurred by much delay. In this connection I venture to say that I think it would be better both for the public and the physician to engage by the year. Let it become the function of the physician not merely to cure disease but to prevent it. By periodical visiting the physician can give such advice and instruction relating to personal, house, school, and I may say business hygiene, as will prevent no little sickness.

Physicians, particularly in city practice are expected to make their calls within a limited number of hours of the day, and patients should remember that his time during this period is precious, and not to keep him waiting while a toilet is made, or a room tidied up. No such infringement upon his time should be made, the professional visit is for a definite purpose and he gives little heed to appearances outside his patient's welfare, his mind being occupied with his professional concerns.

A patient has no right to depart from the instructions of the physician with regard to medicine, or diet, or in any other way. To do so is to risk a danger and to place the physician at a disadvantage. Officious persons often give advice and recommend medicines to the sick; but "patients should never allow themselves to be persuaded to take any medicine whatever, that may be recommended to them by the self-constituted doctors and doctresses who are so frequently met with, and who pretend to possess infallible remedies for the cure of every disease. However simple some of their prescriptions may appear to be it often happens that they are productive of much mischief, and in all cases they are injurious by contravening the plan of treatment adopted by the physician." It too often happens that the nurse, especially, one that calls herself a *trained nurse* who has read only enough to make her little

learning a dangerous thing, will as "fools, rush madly in where angels fear to tread." She wishes to magnify her office and will not hesitate to criticize the treatment and follow it, or change it as she likes.

Many persons thoughtlessly, no doubt, will, while under the care of one physician, seek the opinion and advice of another. I do not refer to a class (I hope not large) who are ever seeking the opinion of medical men respecting their ailments in a casual way, with no intention of offering a fee; but to cases in which the patient is already under treatment and who deliberately go to a second physician, and perhaps a third to obtain an opinion, concealing from each the fact that he is already a patient. This is unfair and not honorable, as any physician may by the use of different terms and language convey the idea of an opinion at variance with that of another, when in reality he holds views precisely the same. It is also reprehensible to call a physician to see a patient under the care of another, which fact is only learned when he reaches the patient; or perhaps he is kept in ignorance. This is gross injustice. We are now and then censured for refusing to see, or prescribe for a patient under such circumstances. It is not many weeks since I was called out of bed and requested by one, whose family I attend, to visit a man supposed to be hopelessly sick, who, I was informed, was under the care of another physician. I was asked to see the patient alone. Of course it is unpleasant to offend a friend, still my duty was obvious. In reply to my suggestion that the attending physician be notified for a consultation, I was somewhat sharply charged with "red-tapeism." Now, I know that my friend in this case spoke without consideration of all the duty which rests upon the physician. This is not merely a question of medical etiquette, the welfare of the public is involved. The principles which guide the profession not only protect its members from interfering with the rights of each other but are a safeguard to the public. If medical men were in the habit of following the footsteps of one another; one prescribing to-day, another to-morrow, and so on according to the behest of vacillating and fickle persons without knowing what the other has done,



it would be impossible to treat patients intelligently and with any prospect of affording relief. And yet because the physician consistently refuses to act so obviously absurd a part he is sometimes not only censured but abused by those who it might be supposed would understand better. It is not long ago that a leading newspaper in the Dominion deliberately stated that "medical etiquette was responsible for a great deal of suffering and death," and that "the medical profession abounds in abuses." These grave and sweeping charges we may hope were made in supreme ignorance of what belongs to a learned and honorable profession, and what is due by that profession to the public.

It is always open to the patient to change his doctor, but an honorable person will not do so without the gravest reasons. If the physician be doing what he can for the patient, it is most unjust to dismiss him in an extreme case of sickness.

Those who have been any time in practice will have experienced a great difference among patients as to considering the convenience of the physician. I suppose we all are afflicted with patients who almost invariably send for us at inconvenient hours. In the country the farmer often will wait until he has finished his day's work, probably because he cannot spare a horse before that time to go for the doctor. The consequence is that he frequently reaches the physician's residence just as he has retired to bed; and you may depend upon this—it is the one who first secures a day's work out of his horse and then drives the tired brute, who will be the one to object to your bill for night service. In the city may be found those who invariably send the summons for the physician after he has started on his daily round, so that when he comes home, he has to retrace his way at once, for this class are usually very urgent in their request. There is also a class who make it a rule to call upon the physician at the hours for meals so as to catch him at home. Now, while the physician will cheerfully respond to any call when an emergency makes delay impossible, and a timely notice is out of the question, and will leave his bed or the table uncomplainingly, it is manifestly inconsiderate and exacting to cause him inconvenience, and

infringe upon the hours required for refreshment and repose.

One more duty of the patient toward the physician I will refer to,—namely, to make a proper and, if possible, prompt acknowledgment for services rendered. Why is it that the doctor's bill should so often be the last paid? And there are some who feel offended when the physician renders his account under six months or a year.

The physician rarely asks for his fee when called upon, and it should be a matter of honour with the patient to pay for services without waiting for an account to be rendered. I am speaking of those who would scorn to be regarded as intentional defrauders; but there is a class of beings, I can hardly say human, who, no matter how much care and anxiety they have given the physician, never will remunerate him. Probably give abuse instead.

#### OF THE DUTIES OF PHYSICIANS TO EACH OTHER, AND TO THE PROFESSION AT LARGE.

"Every individual, on entering the profession, as he becomes entitled to all its privileges and immunities, incurs an obligation to exert his best abilities to maintain its dignity and honor, to exalt its standing, and to extend the bounds of usefulness. He should, therefore, observe strictly such laws as are instituted for the government of its members; and while, by unwearied diligence, he resorts to every honorable means of enriching the science, he should entertain a due respect for his seniors, who have, by their labors, brought it to the elevated condition in which he finds it.

"There is no profession, from the members of which greater purity of character and a higher standard of moral excellence are required, than the medical; and to attain such eminence is a duty every physician owes alike to his profession and to his patients. It is due to the latter, as without it he cannot command their respect and confidence; and to both, because no scientific attainments can compensate for the want of correct moral principles. It is also incumbent upon the faculty to be temperate in all things, for the practice of physic requires the unremitting exercise of a clear and vigorous understanding; and, on emergencies, for which no professional man should be unprepared, a steady hand, an acute eye, and an unclouded head may be essential to the well being, and even to the life, of a fellow-creature.

"It is derogatory to the dignity of the profession to resort to public advertisements, or

private cards, or handbills, inviting the attention of individuals affected with particular diseases—publicly offering advice and medicine to the poor gratis, or promising radical cures; or to publish cases and operations in the daily prints, or suffer such publications to be made; to invite laymen to be present at operations, to boast of cures and remedies, to adduce certificates of skill and success, or to perform any other similar acts. These are the ordinary practices of empirics, and are highly reprehensible in a regular physician.

"In the case, however, of a physician or surgeon commencing the practice of his profession, or removing to another locality, a simple announcement by an unobtrusive card in the public prints is unobjectionable.

"Equally derogatory to professional character is it for a physician to hold a patent for any surgical instrument or medicine; or to dispense a secret *nostrum*, whether it be the composition or exclusive property of himself or others. For, if such *nostrum* be of real efficacy, any concealment regarding it is inconsistent with beneficence and professional liberality; and if mystery alone gives it value and importance, such craft implies either disgraceful ignorance or fraudulent avarice. It is also reprehensible for physicians to give certificates attesting the efficacy of patent or secret medicines, or in any way to promote the use of them.

To the foregoing I would add, that it is objectionable for the physician to resort to any unusual method of making himself known or spoken about. By peculiar personal dress, or manner, or equipage, or office-surrounding, to gain the attention of the public, is unprofessional. Excentricity is no longer regarded by the discerning public as an indication of genius or skill; nor will, what I may be allowed to call *loud* manners, secure the most desirable *clientèle*.

There is another mode of attracting the public attention none the less a violation of the code of professional honor still pursued by a few, namely, making unnecessary display in the performance of surgical operations. And in connection with this I must refer to the unjustifiable practice, perhaps I should say criminal practice, of performing an operation without the slightest expectation of benefitting the patient. For a surgeon to mutilate a body, or increase the suffering of a patient afflicted with an incurable disease, merely to exhibit the operator's knowledge of anatomy and steady hand, is to make him an object of scorn and

loathing. A surgeon who will perform, of two operations, the more dangerous one because it may give him a name, is unworthy of esteem, and should the unnecessary operation prove fatal he would be really guilty of manslaughter.

#### PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER.

Upon the duties of physicians in relation to each other, I need not dwell, as their principles are usually inculcated when the medical education is received, and are strictly observed by the high-minded physician; and I have already made some remarks bearing upon the subject. But I may remind you, and I wish I could remind some who are not present, that in case of consultations the strictest punctuality is demanded. I regret to have to say that now and again we meet with one who, because of his standing, thinks he may transgress this law of good manners. But the law is so manifestly just that no excuse can be accepted for careless delay in keeping professional appointments. And this law applies to cases of hospital consultations as well as to private practice. No one, however much a senior or uplifted, has a right to withhold from any one he meets in consultation the treatment due to a *confrère*.

For one to seek at a consultation by any mode to produce an impression upon the patient, or his friends, that the attending physician is untrustworthy, or that he himself is more wise and skilful, is a gross violation of the golden rule upon which our code is founded. True greatness is always retiring and considerate for the feelings and character of others. It is gratifying to believe that instances of unprofessional behaviour in this respect are becoming less and less frequent.

If in consultation a physician cannot accept the opinion and views of another, and believes that the welfare of the patient is involved, it is his duty to adhere to his decision, and if necessary withdraw from the case. But such instances are extremely rare. In the words of the code:—

"All discussions in consultation should be held as secret and confidential. Neither by words nor manner should any of the parties to a consultation assert or insinuate that any part of the treatment pursued did not receive his



assent. The responsibility must be equally divided between the medical attendants—they must equally share the credit of success as well as the blame of failure.

“The consulting physician should also carefully refrain from any of those extraordinary attentions or assiduities which are too often practiced by the dishonest for the base purpose of gaining applause, or ingratiating themselves into the favour of families and individuals.

“A physician ought not to take charge of or prescribe for a patient who has recently been under the care of another member of the faculty in the same illness, except in cases of sudden emergency, or in consultation with the physician previously in attendance, or when the latter has relinquished the case, or been regularly notified that his services are no longer desired. Under such circumstances, no unjust, illiberal insinuations, should be thrown out in relation to the conduct or practice previously pursued, which should be justified as far as candor and regard for truth and probity will permit; for it often happens that patients become dissatisfied when they do not experience immediate relief, and, as many diseases are protracted, the want of success in the first stage of treatment affords no evidence of a lack of professional knowledge and skill.

“When a physician is called to an urgent case, because the family attendant is not at hand, he ought, unless his assistance in consultation be desired, to resign the care of the patient to the latter immediately on his arrival.

“It often happens in cases of sudden illness, or of recent accidents and injuries, owing to the alarm and anxiety of friends, that a number of physicians are simultaneously sent for. Under these circumstances, courtesy should assign the patient to the first who arrives, who should select from those present any additional assistance that he may deem necessary. In all such cases, however, the practitioner who officiates should request the family physician, if there be one, to be called, and, unless his further attendance be requested, should resign the case to the latter on his arrival.

“When a physician is called to the patient of another practitioner, in consequence of the sickness or absence of the latter, he ought, on the return or recovery of the regular attendant, and with the consent of the patient, to surrender the case.

“A physician, when visiting a sick person in the country, may be desired to see a neighbouring patient who is under the regular direction of another physician, in consequence of some sudden change or aggravation of symptoms. The conduct to be pursued on such an occasion is to give advice adapted to present circumstances; to interfere no further than is abso-

lutely necessary with the general plan of treatment; to assume no future direction, unless it be expressly desired; and, in this last case, to request an immediate consultation with the practitioner previously employed.

“A wealthy physician should not give advice gratis to the affluent, because his doing so is an injury to his professional brethren. The office of a physician can never be supported as an exclusively beneficent one; and it is defrauding, in some degree, the common funds for its support, when fees are dispensed with, which might justly be claimed.”

The physician in active practice requires yearly a rest from its cares and responsibilities. In seeking recreation he has a right to ask a neighbouring brother practitioner to officiate for him. No physician will decline to render such a service. Of course, if the period of absence be prolonged, or the absentee is rather in the pursuit of amusement than recreation, he should not receive from him who labors the fees earned. A physician who is thus trusted by another will not, if an honourable man, endeavour by artifice or intrigue to alienate the patients from their regular attendant.

The instances where a physician is justified in visiting the patient of another practitioner as a friend are very rare. If urgent business or relationship make a visit necessary, the physician will be scrupulously careful to avoid even the approach to a consideration of his disease or of the treatment being pursued.

While the physician will always consider it a pleasing duty to give professional attendance to a neighbouring *confrère*, or his family, when asked to do so, without remuneration, he should not be requested to travel any distance or sacrifice much time without the offer of an *honorarium*, nor should he hesitate to accept it.

By mutual understanding there should be adopted in every community a tariff of fees, to be strictly observed by all. To depart from this on the part of one is to make him chargeable with double-dealing and adopting a disreputable mode of gaining popularity.

#### DUTIES OF THE PROFESSION TO THE PUBLIC.

“As good citizens it is the duty of physicians to be ever vigilant for the welfare of the community, and to bear their part in sustaining its institutions and burdens. They should also be ever ready to give council to the public in

relation to matters especially appertaining to their profession, as on the subject of medical police, public hygiene, and legal medicine. It is their province to enlighten the public in regard to quarantine regulations—and in regard to measures for the prevention of epidemics and contagious diseases; and when pestilence prevails, it is their duty to face the danger and to continue their labours for the alleviation of the suffering, even at the jeopardy of their own lives.

"Medical men should also be always ready when called upon by the legally constituted authorities, to enlighten coroners' inquests and courts of justice, on subjects strictly medical—such as involve questions relating to sanity, legitimacy, murder by poisons and other violent means, and in regard to the various other subjects embraced in the science of medical jurisprudence. But in these cases, and especially where they are required to make a post-mortem examination, it is just, in consequence of the time, labor, and skill required, and the responsibility and risk they incur, that the public should award them a proper honorarium. Medical men should also be properly paid for attendance as witnesses in criminal cases.

"There is no profession by the members of which eleemosynary services are more liberally dispensed than the medical; but justice requires that some limits should be placed to the performance of such good offices. Poverty, professional brotherhood, and certain of the public duties referred to in the first section of this article, should always be recognized as presenting valid claims for gratuitous services; but neither institutions endowed by the public or rich individuals, societies for mutual benefit, for the insurance of lives (the certificates for which should be sent confidentially to the company and paid for), whether furnished by the medical adviser of the company or by the family physician, or for analogous purposes, nor any profession or occupation, can be admitted to possess such privilege."

#### OBLIGATIONS OF THE PUBLIC TO THE PROFESSION.

It must be said the public are not disposed to recognize the services of the medical profession, and to avail themselves of their scientific knowledge for the welfare of communities and the State. The salary for a medical health officer, or fees for professional services, are usually grudgingly paid. Notwithstanding the continued efforts of the profession to educate the public in sanitary laws, and prevail upon legislators to enact such laws and create such organizations as will prevent sickness and pro-

long human life, there seems to be a settled indifference on their part. It might be supposed that conduct, so unselfish, indeed so calculated to diminish the ordinary work of the physician—and at the same time to secure a saving to the individual, to communities, and to the State—would engage the warmest attention of the rulers of the land.

However, I am glad to be able to say that there is a probability of some action being taken by the Dominion Government. A Committee was appointed by this Association at its last meeting, "to continue communication with the Dominion Government, with a view of securing a grant towards carrying out an effective system of health registration." When the report of this Committee is presented, you will learn that the Premier, Sir John A. Macdonald, is not indifferent to the representations which the medical profession have made to him regarding vital statistics and State medicine, and that, had not illness prostrated him last winter, (an illness which I am sure all Canadians deplore,) steps would have been taken ere this to meet the wishes of this Association so far as the Constitution will permit.

Before concluding, allow me to express my deep concern that the continued sickness of our respected General Secretary has made it necessary for him to resign his post, a position he has so long worthily filled. I am sure you will unite with me in wishing his speedy restoration to health. As you can understand, the absence of Dr. David, who was quite familiar with our Constitution and the working of the Association, is a serious loss to myself in the discharge of my duties; but I am thankful to say that Dr. A. H. Wright, whom I requested to act as General Secretary, has, in making the arrangements for this meeting, very adequately filled the vacancy so unfortunately made.

I thank you, Gentlemen, for the kind hearing you have given me, and beg you will generously aid me in the work which falls to me as your presiding officer.

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Professor Austin Flint, of New York, has received the degree of LL.D. from Yale College.




THE CANADIAN  
*Journal of Medical Science,*

A Monthly Journal of Medical Science, Criticism,  
 and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, AUGUST, 1881.

 We have delayed the appearance of this issue in order to present our readers with the text of the President's Address, delivered at the meeting of the Canada Medical Association, in Halifax, on the 3rd inst., and have extended the issue to 36 pages.

THE INTERNATIONAL MEDICAL CONGRESS.

The International Medical Congress of 1881 meets in London this month, from the 2nd to the 9th, inclusive. Notwithstanding that in the past crowned heads and municipal corporations in other lands have vied together to do honour to our craft on such occasions and ensure the success thereof, yet the coming meeting in the world's metropolis gives ample promise of exceeding both in scientific interest and utility all its predecessors. The Congress will open under the Presidency of the veteran, Sir Wm. Jenner, universally acknowledged, alike in scientific attainments, clinical skill and judgment, didactic power and probity of character, the head of the profession in the Motherland. He will deliver the address of welcome, but fears are entertained that he may not be able to take an active part in the scientific discussions of the meeting. Addresses will be delivered by Sir James Paget, the most accomplished of British medical orators, by Professor Huxley, on the Connection of the Biological Sciences with Medicine; by Prof. Volkmann (in German), on Modern Surgery; by Rudolph Virchow, on the Bearing of Pathological Experiments on Medicine; by Surgeon Billings, on Medical Literature; and Prof. Maurice Ray-

naud, the most polished and brilliant of French medical orators (whose names are many) was to have read an address on Scepticism in Medicine in Past and Present Times; but his lamentably sudden death from angina pectoris, on the 30th of June, has marred this, one of the most attractive features of the programme. The address, however, has been found completed, and it is hoped that M. Noel Gueneau de Mussy will perform the painful but still pleasing duty of giving utterance to his dead friend's words.

It is expected that between 2,000 and 3,000 medical men will be in attendance, and as many of the powers have nominated representatives to attend, and many of the first names in medicine have promised to be present, it seems likely that a totally unprecedented gathering of the sons of Æsculapius will be witnessed.

The business of the Congress will be transacted in 16 sections, most of which will meet in the various scientific societies' rooms in Burlington House, and the remainder in the Royal Institution, Willis's Rooms, the University of London, Burlington Gardens, and the Royal School of Mines. The social features will be as numerous and attractive as the time unoccupied by business will allow. Her Majesty has expressed the interest she feels in the occasion; and the Prince of Wales will attend the opening meeting, lunch with Sir Jas. Paget, and dine with Sir Wm. Gull, the Presidents, and Vice-presidents of sections, and distinguished foreigners, and attend the reception in the South Kensington Museum. Fetes, soirees, dinners, and excursions have been arranged for, and the ancient corporation of the city of London extends the hospitality of the city on its usual magnificent scale, placing at the disposal of the Reception Committee two thousand invitations, and issuing an additional one thousand on its own account, for a conversazione in the Guildhall.

TORONTO SCHOOL OF MEDICINE.

We are glad to notice that this well-known medical school has made the most complete arrangements for giving, during the next session, a thoroughly practical and scientific

course of instruction in every department. We quote the following from the announcement which has been recently issued:—

"Since the issue of our last annual announcement important changes have been made which, it is confidently expected, will materially strengthen the Institution, and give increasing effect to the work done in the various departments. Associate Lecturers have been appointed in the principal subjects of the course, who will be prepared to carry on the work in the absence, from sickness or otherwise, of the regular lecturers. The Faculty, in announcing this change, hope that it will commend itself to the friends of the School, as an important step in the interests of intending students.

"Arrangements are in progress for a more complete course of clinical instruction, and it is hoped that, through this, associated with the didactic course, the Faculty will be able to offer advantages of a very superior character to those entering upon medical studies. - They will continue to devote their best efforts to the attainment of these ends."

The following appointments have been made, as appear in advertisement in this issue: Dr. W. W. Ogden, to be Adjunct Lecturer on Midwifery; Dr. M. H. Aikins, Adjunct Lecturer on Surgery; Dr. W. Oldright, Adjunct Lecturer on Medical Jurisprudence; Dr. L. McFarlane, Adjunct Lecturer on Anatomy; Dr. George Wright, Adjunct Lecturer on Materia Medica and Therapeutics; Dr. John Ferguson, Assistant Demonstrator of Anatomy; Dr. A. H. Wright, Assistant Secretary.

#### HOWARD'S METHOD OF ARTIFICIAL RESPIRATION.

We think it advisable at this season to direct attention to the following rules for resuscitating the partially drowned:—

1. *Instantly* turn patient downward, with a large firm roll of clothing under stomach and chest. Place one of his arms under his forehead, so as to keep his mouth off the ground. Press with all your weight two or three times, for four or five seconds each time, upon patient's back, so that the water is pressed out of lungs and stomach, and drains freely out of mouth. Then

2. *Quickly* turn patient, face upward, with roll of clothing under back, just below shoulder blades, and make the head hang back as low as

possible. Place patient's hands above his head. Kneel with patient's hips between your knees, and fix your elbows firmly against your hips. Now, grasping lower part of patient's naked chest squeeze his two sides together, pressing *gradually* forward with all your weight, for about three seconds, until your mouth is nearly over mouth of patient; then, with a push, *suddenly* jerk yourself back. Rest about three seconds; then begin again, repeating these bellows-blowing movements with perfect regularity, so that foul air may be pressed out, and pure air be drawn into lungs, about eight or ten times a minute, for at least an hour, or until the patient breathes naturally.

McGILL UNIVERSITY, FACULTY OF MEDICINE, SUMMER SESSION, 1881. Examination for Clinical Prize (\$50 Microscope), offered by Dr. Osler. Drs. George Ross and W. Osler, Examiners.

I. Written paper, one and a half hours.

1. A man, aged 40, comes to you complaining of headache, vomiting and dimness of vision; pulse 70, temperature normal; general health has been tolerably good; present illness came on after a few days' indisposition.

State (a) your method of procedure in the examination of patient; (b) the conditions which might bring about such symptoms, and the points to be attended to in distinguishing between them.

2. How would you proceed to map out the liver dullness? State its normal limits. Mention conditions associated with (1) increase, (2) diminution of its area.

3. Distinguish between the conditions you have met with during the Session, accompanied by a dull percussion note in one infra-scapular region.

4. Sketch the main features of any case of heart disease which you have studied during the Session.—150 marks.

II. A case to diagnose and prepare a written report upon. Condition of fundus oculi and larynx to be given.—One hour. 150 marks.

III. Examination of sputa, vomit, feces, and urine; chiefly microscopical.—Twenty minutes.—50 marks.

Mr. R. J. B. Howard, B.A., was the successful candidate, obtaining 322 out of the possible 350 marks.



## ASSOCIATION OF SUPERINTENDENTS OF ASYLUMS.

The 35th annual meeting of the Association of Medical Superintendents of American Institutions for the Insane, was held in the Rossin House, Toronto, on Tuesday, 14th June, and the three following days, under the Presidency of Dr. John H. Callender, of Nashville, Tenn., the Vice-president, in the unavoidable absence of the President, Dr. Walker. Forty-one members were present, and by the courtesy of the Association a number of local and other gentlemen, and the members of the profession generally in the city were invited to attend. Memoirs of Drs. Isaac Ray, W. S. Chipley, Joseph T. Webb, and Robt. F. Baldwin, deceased members of the Association, were read and entered on the minutes. Papers were read by Dr. Everts on the "American System of Public Provision for the Insane, and Despotism in Lunatic Asylums;" Dr. Joseph Workman on "Some Points in the Management of American Institutions for the Insane" (which we hope to publish soon); Dr. Hughes, on "Cephalic and Spinal Electrization;" Dr. Hurd on "A Plea for Systematic Therapeutical, Statistical, and Clinical Study of Mental Disorders;" Dr. Fauntleroy on "A Case of Extensive Gunshot Injury to Brain without Mental Disorder;" Dr. Barksdale on "A case of Extraordinary Size of Brain and Skull in a Negro;" Dr. Gundry on "Separate Institutions for certain Classes of the Insane;" and a further paper by Dr. Hurd, containing the report of a case with post-mortem examination. Drs. C. Lockhart Robertson, England; A. Motet, Paris, Tamburini, Italy, and F. S. Clouston, Scotland, were elected honorary members. The members visited the chief points of interest in the city and suburbs; were entertained at dinner by the Ontario Superintendents, and the Inspector of Asylums and Prisons, Mr. Langmuir; were received with their ladies at Government House, by Hon. John Beverley and Mrs. Robinson; attended a moonlight excursion on the *Chicora*, given by the Ontario Government; an excursion to Lorne Park, given by the New England Society, and a conversazione in the Normal School

building, given by the medical Profession of the city. Many expressions of friendship and confraternity were interchanged, and after numerous valedictory resolutions of gratulation and goodwill the meeting adjourned at half-past 11, on Friday night, to meet again in Cincinnati, Ohio, on 30th May, 1882. Ten years have elapsed since the Association last met within our walls. May the next decade again give them welcome in our midst, and also witness an equal advance in material prosperity and scientific progress with the past!

## MEETING OF THE CANADA MEDICAL ASSOCIATION.

All indications point to a successful meeting of this Association at Halifax, on the 3rd of August. The Hon. Dr. Parker, Dr. Lawson, and others of Halifax, have been most assiduous in their endeavours to make every preparation for the reception of those attending, and, in their labours, have received kind assistance from many in the Provinces of Nova Scotia, New Brunswick, and Prince Edward Island; and we feel assured that those from the "far West" in Ontario, as well as those from Quebec, will feel amply repaid for their journey to "the East," although it may be a very long one. We will miss some familiar faces, as a number of the most faithful members, such as Drs. Howard, Osler, Rosebrugh, Grant, and Reeve, will in the same days be acting in the larger sphere of the International Medical Congress, in London.

The Meeting will be held in the Council Chamber of the Government Buildings. The Government of Nova Scotia, kindly appreciating the importance of the gathering, will do the Association the honor of entertaining them at a dinner. It will be a source of great disappointment to many to find that the genial, hospitable, and well-known Vice-president of Nova Scotia, Dr. Parker, will be compelled, by the cruel fates of unavoidable and accidental circumstances, to be absent.

Among the papers promised, we may mention, first, the address of the President, Dr. Canniff. Subject: "Medical Ethics." Paper by Dr. Oldright, of Toronto, on "Local Treat-

ment of Empyema; Dr. Grant, of Ottawa, "The Stomach Pump;" Dr. Osler, of Montreal, "On the Theory of Intra-pleural Râles;" Dr. Bessey, of Montreal, "Vaccination with Calf Lymph;" Dr. Worthington, of Clinton, Ont., "Treatment of Scarlatina Maligna by Cold Water and Ice;" Dr. Fenwick, of Montreal, "Antiseptic Treatment in Ovariectomy and Knee Excisions;" Dr. J. W. Macdonald, Londonderry, N. S., "Water Analysis," and will exhibit a "case containing chemicals and apparatus for the examination of water;" Dr. Stewart, of Brucefield, Ont., "Treatment of Exophthalmic Goitre by Ergot;" Dr. Coleman, of St. John, N. B., "The use of the Ophthalmoscope in the Diagnosis of Brain Disease."

CRUDE PETROLEUM IN PHTHISIS.—Dr. Strothers in the *Philadelphia Medical and Surgical Reporter*, claims good results from the use of crude petroleum in phthisis. He gives it in four-grain doses, in pill or capsule, and finds it superior to cod-liver oil.

NEW YORK PATHOLOGICAL SOCIETY.—Dr. George F. Shrady acted for twenty-two years as Secretary of this Society, and at a meeting, held June 22nd, was presented with an elegant silver pitcher and salver, as a "small token of grateful remembrance of his great services."

PERSONALS.—Dr. A. C. Jones, who was last month married to Miss Pickering, of Toronto, has commenced practising in Cumminsville, Ontario.

Dr. Wm. McClure, who was formerly practising in Cumminsville, has removed to Niagara Falls.

Dr. Martin, formerly of Oshawa, is now practising in Toronto, No. 98 Carlton St.

Dr. Edmondson, and Mr. J. T. Duncan, are at present attending St. Thomas' Hospital, London.

Drs. Howitt, Montgomery, and Nicholson sail for London, August 3rd.

Mr. A. S. Patullo, aged 20, second son of Dr. Patullo, of Brampton, died July 19th.

## Book Notices.

*The Management of Wounds.* By DAVID PRINCE, M. D. Philadelphia: Lindsay & Blakiston.

*Twelfth Quarterly Report of the Pennsylvania Board of Agriculture.* March, April, May, 1881.—Harrisburg.

*Transactions of the American Dermatological Association, with the President's Address. 4th Annual Meeting. Official Report of the Secretary,* ARTHUR VAN HARLINGEN, M.D.

*Hip Injuries, including Hipjoint Disease and Fracture of the Femoral Neck, Splint for.* By DE F. WILLARD, M.D., Lect. Orthopædic Surgery, University of Pennsylvania. (Reprint from *Phil. Med. Times*.)

*Hip-joint Disease, Death in Early Stage, from Tubercular Meningitis.* By DE F. WILLARD, M.D. Microscopical appearances, with cuts. By E. O. SHAKESPEARE, M.D. (Reprint from *Boston Med. and Surg. Jour.*)

*Contribution to the Correction of Strabismus by the Advancement of the Rectus* (with photographs). By A. E. PRINCE, M.D., Jacksonville, Ill. (Reprint from *St. Louis Med. and Surg. Jour.*)

*The Management of the Perineum during Labour, and the Immediate Treatment of Lacerations, and the Obstetrics and Gynaecology of William Harvey.* By F. H. STUART, A.M., M.D. Brooklyn.

The *Ohio Medical Journal* makes its debut with the July number, in the room and stead of the *Ohio Medical Recorder*, and as the journal of the Ohio Medical Society whose transactions it will embody. We give it a hearty welcome.

*Des Intermittences du Pouls, de la Syncope, et de la Mort Subite dans la Convalescence de la Fièvre Typhoïde.* Par le DR. LANGLET. (Extrait de *L'Union Médicale et Scientifique du Nord-Est.*) Reims: Chez Deligne, 5 Rue du Cadran, Saint Pierre.



*Ether Death.* A Personal Experience in Four Cases of Death from Anæsthetics. By JOHN B. ROBERTS, A.M., M.D., Lecturer on Anatomy and Operative Surgery, in Philadelphia School of Anatomy. (Reprint from the *Philadelphia Medical Times*.

*The Illustrated Scientific News.* The July number of this highly interesting and instructive illustrated periodical has been received, and presents amongst other valuable matter, an illustrated account of the Dobear Telephone, Glass Grinding Machine, Ancient Pottery from Cyprus, Mechanical Larynx, the Remarkable Palmyra Palm, Curious Fishes, the Bursting of a Fly-wheel, etc. The enterprising publishers Messrs. Munn & Co., 37 Park Row, New York, deserve the support of the profession and the intelligent public generally; and we cordially commend this enterprise which places within the reach of all, this very excellent verbal and pictorial account of many curiosities and inventions of scientific and general interest, for the moderate sum of \$1.50 a year.

*Atlas of Gynæcology and Obstetrics.* Edited by DR. A. MARTIN, Prof. of Gynæcology, University of Berlin. Containing 475 black, and 37 coloured illustrations from the original designs of the best known names in Obstetric Medicine and Pathological Anatomy, and supplemented by numerous drawings from J. P. Maygrier's *Nouvelles Demonstrations D'Accouchements*. Cincinnati, O.: A. E. Wilde & Co., Publishers.

The first four numbers of this admirable work have come to hand. The title above cited sufficiently sets forth its character and scope, and the name of Martin, of Berlin, will be a sufficient guarantee of the excellence of the production. Many of the plates will be found to be old and familiar friends, having been adopted from such authors as Beigel, Virchow, Hyatt, Nægele, Schröder, Rokitansky, Busch, Hueter, Duges, Hodge, Blume, Boivin, Dubois, Hunter, Braune, Moreau, Duncan, Wagner, Kiersch, Cruveilhier, Olshausen, etc. Such a collection can nowhere else be had, and the price demanded is absurdly small. The work is sold only by subscription; and we sincerely trust that a long list may amply repay the enterprise manifested by the Publishers.

*Atlas of Skin Diseases.* By LOUIS A. DUHRING, M.D., Prof. of Skin Diseases in the Hospital of the University of Pennsylvania, etc. Part IX. Philadelphia: J. B. Lippincott & Co. 1881.

Part IX. of the concluding number of this well-known, and justly much-lauded *Atlas of Skin Diseases* is now before the public. It comprises two plates of Eczema Rubrum and one each of Pemphigus and Ecthyma. The vocabulary of commendation has been so nearly exhausted in the notices on all hands of the previous numbers of the series, that no meed of praise remains for this final part, other than an iteration of the merits and characteristics of its predecessors, viz.:—truthfulness to life and excellence of mechanical execution. We congratulate the author upon the high standard and sterling worth of the work he has produced; the artists and publishers upon the admirable manner in which their part has been performed and the professional public upon their good fortune in now having, within easy reach, so excellent a portrayal of the most important diseases of the skin, of which, we are sorry to say, so many know so little.

*Zoological Atlas*, (including comparative anatomy), illustrating a series of Typical Forms, Representing the Chief Divisions of Animal Life by Drawings of Specimens and Dissections, with practical Directions and explanatory Text. By Dr. McAlpine, F.C.S., Lecturer on Biology and Natural History, Edinburgh. Imperial quarto, Full bound cloth, in two parts. Vertebrate, 24 full-coloured plates. Invertebrate, 16 ditto. Edinburgh: W. & A. K. Johnston.

We are in receipt of the first part of this excellent atlas, dealing with the anatomy of the vertebrata, and comprising 5 plates illustrating the anatomy of the skate, 4 of the cod, 1 of the salamander, 3 of the tortoise, 4 of the pigeon, and 7 of the rabbit. The drawings are very well executed throughout, and the colouring good; the whole conveying an excellent idea of the parts and forms depicted. An explanatory text facing each plate and clearly indicating and describing the parts portrayed, of course greatly enhances their value to the student, as do also the accompanying practical directions. We unhesitatingly recommend the work to all who are commencing the study of zoology.

*Anatomical Studies upon Brains of Criminals.*  
By MORIZ BENEDIKT, Professor at Vienna.  
Translated from the German by E. P. Fowler, M.D. New York: Wm. Wood & Co., 1881.

The object of this work, published in Germany some three or four years ago, is to show that "the cerebral constitution of criminals exhibits mainly deficiency—deficient gyrus development—and a consequent excess of fissures, which obviously are fundamental defects." And this being generalized throughout, the brain substance does not admit of compensation by vicarious functioning. The introduction sets forth by means of figures and verbal description the normal character of the cerebral convolutions and fissures, and contrasts therewith the appearances presented by brain specimens from criminals. Then follows the record of twenty-two observations of criminals convicted of different offences, together with reproductions (by means of photo-engravings which are more permanent and durable than the photographs in the original) of the brain surfaces and sections. Four sections devoted to a recapitulation of the facts brought out by the observations, together with deductions, complete the work. Speaking generally, the book may be described as a really valuable "contribution to anthropology, medicine, jurisprudence, and psychology," and having been prepared for the information of lay as well as professional readers, by the avoidance, as far as possible, of technicalities, it may justly be expected to exercise a wide influence in the community. Dr. Fowler deserves the thanks of all interested for his very excellent translation.

*An Introduction to Pathology and Morbid Anatomy.* By T. Henry Green, M.D., Lond., Lecturer on Pathology and Morbid Anatomy at Charing Cross Hospital Medical School. Fourth American, from the fifth Revised and Enlarged English Edition with 138 fine engravings. Philadelphia: H. C. Lea, Son, & Co., 1881.

This very excellent hand-book of Pathology needs no commendation at the hands of the reviewer, its great merits and advantages for the student being already so widely known. In this latest edition we observe certain

changes in the chapters on Nutrition Arrested, and Nutrition Increased, designed to bring the text up to the latest advances in our knowledge in this department. Psammoma is here classed amongst the Fibromata, and not as heretofore with the Sarcomata. We miss, however all notice of Cylindroma. Some slight changes in the text on Inflammation, and an addition treating of the terminations of this process have been introduced. A newer definition of Septicæmia has been adopted, and Koch's contributions duly acknowledged. The chapter on Leukæmia has been re-written and much improved. The distinction between Fibrinous and Croupous Inflammations is not recognized, or maintained in this edition. The croupous and diphtheritic processes are regarded as one; and a better description of them given than in the previous editions. Some slight alterations have been introduced in the account of Cirrosis of the Liver, and Hypertrophic Cirrosis more fully recognized, but not yet sufficiently admitted as a distinct affection to meet the views of certain French Pathologists. All the good things that have been said and written of previous editions apply with added force to this, and we know not how to recommend the book too highly to all students and to those practitioners who have not a recent edition, and who care to know the why and wherefore of those processes which fall under their daily observation.

It has been announced that the following is to be the *personnel* of the new Medical School in London, Ont., connected with the Western University:—Dean and Prof. of Surgery, Dr. Moore, sen.; Medicine, Dr. Fraser; Midwifery, Dr. Moore, jun.; Diagnosis and Therapeutics, Dr. Stevenson; Jurisprudence, Dr. Jones; Nervous and Mental Diseases, Dr. Bucke; Sanitary Science, Dr. Fenwick; Clinical Surgery, Dr. Niven; Clinical Medicine, Dr. Arnott; Anatomy, Dr. Waugh; Physiology, Dr. Eccles; Histology and Etiology, Dr. Moorehouse; Botany, Dr. Burgess; Mat. Med., Mr. William Saunders, the well-known druggist; and Chemistry, Prof. Bowman. We have heard one of the oldest members of the oldest school in Ontario express the opinion that the separation of Mat. Med. and Therapeutics, and the allotment of the former to a practical druggist, was most excellent feature in the management.



## Meetings of Medical Societies.

### ONTARIO MEDICAL ASSOCIATION.

(Concluded from page 232.)

#### AFTERNOON SESSION.

The President took the chair at 2 o'clock.

Dr. Campbell stated that he had a resolution to propose, and in introducing it referred in eloquent terms to the fact that no gentleman of their profession wished to profit by the afflictions of others. Their object was two-fold, viz., the prevention as well as the cure of disease, and the former was of as much importance to the public as the latter. If the school teachers would impart instruction in hygiene and the laws of health these laws would become better known, and the result be a decrease in the death rate. Some years ago, in speaking before the North Huron Teachers' Association, he had stated it as his opinion that there were too many "ologies," and he believed so still. There are many diseases that can be prevented far more readily than cured, and one of these is phthisis. The proper ventilation of schools, especially in the rural districts, is greatly neglected, and thus the seeds of consumption are sown. He expressed it as his opinion that if a little book on the subject of hygiene were introduced into our schools a great improvement in the general health of the community would be the ultimate result, and if drainage were better understood, cases of typhoid would be less frequent, and this subject could be incorporated in the text-book he had just mentioned. He then read the following resolution, moved by Dr. Campbell, seconded by Dr. Worthington, "That in view of the very widespread ignorance among the masses of the people of the simple laws of health, and of the sickness which frequently arises from this ignorance, this association is unanimously of opinion that if the subject of hygiene with some of the essential elements of physiology were substituted in the Public Schools for one or more of the much less essential subjects now commonly taught, and were made compulsory and taught in the Public Schools throughout this province, so soon as pupils arrived at an age at which they could comprehend the same, it would tend in no small

degree to prevent sickness, and to promote the wellbeing of the people of this province; and that the following be a special committee to urge upon the Minister of Education the desirability of an early change being made in the schools in this behalf." The names of the gentlemen forming the committee to be Drs. G. Wright, J. Fulton, Canniff, the mover and seconder.

In rising to second the resolution, Dr. Worthington said it was now some years since any book on hygiene had been taught in our schools, and agreed with the mover that if this subject were taught in our schools, the ultimate result would be a marked improvement in the general health. He had great pleasure in seconding the motion.

Dr. Bowlby, of Berlin, said that teachers, unless educated to it, could not give the necessary instruction.

Dr. Curry thought there were too many subjects for study in schools. They had too much overwork, and this was as bad as too little ventilation. He knew several cases where health had been injured by overtaxing the intellect, and thought that the Association should give this subject their attention. It would be better for the children, their parents, and every one else.

Dr. Oldright said that in some schools they had shortened the hours, but cut out the recess in the morning, and if there was anything that assisted the children it was that morning recess. He thought the trouble was not so much in sending children to school when, as some imagined, they were too young, but in giving them too much to do when they got there. The only idea some teachers seemed to have on the subject of ventilation was that when a school-room became too warm all they had to do was to throw open the doors and windows, and this in winter time was anything but pleasant for the scholars.

Dr. McDonald and others also endorsed the remarks of the previous speakers.

The President before putting the resolution made some remarks of an interesting character. Last year he read three papers on the subject of brain overwork, and expects to read another before the Teachers' Association before long.

He gave it as his opinion that the rate of consumption among teachers is three times greater than the members of other professions, and the same might be said of insanity. With regard to the suggested text-book, he thought if introduced it would only be one more added to the long list of subjects now taught in our schools.

Dr. McGregor moved, seconded by Dr. MacDonald, that the resolution be referred to the Committee on Public Health, to report on at the next annual meeting. Carried.

A resolution by Dr. Sloan, to the effect that when the meeting of the Dominion Medical Association was held in a convenient locality in Ontario the meeting of this Association be united or merged in theirs, was, after some discussion, withdrawn.

Dr. Powell, of Edgar, then read notes of a case of diastasis of the upper ends of the tibiae presenting casts and photographs of the deformity.

This was followed by a paper by Dr. Yeomans, of Mount Forest, on empyema, after the reading of which Dr. Oldright, of Toronto, showed two cases in which he had practised intermittent drainage and irrigation on a special plan which he described, and a general discussion was elicited, in which Drs. Oldright, Fulton, and Ross, sen., of Toronto, Malloch, of Hamilton, and Bowlby, of Berlin, participated.

Dr. Stewart, of Brucefield, contributed a paper on the use of coto bark, in the night sweats of phthisis.

An intermission of ten minutes ensued, at the end of which, the Nominating Committee presented their report, and the following gentlemen were unanimously elected as officers for the ensuing year, viz.:—President, Dr. Covern-ton; vice-Presidents, 1st, Dr. Mullin, Hamilton; 2nd, Dr. Yeomans, Mount Forest; 3rd, Dr. Hamilton, Port Hope; and 4th, Dr. Irwin, Kingston; Secretary, Dr. White; Treasurer, Dr. Graham, both of Toronto. The various Committees are the same as this year.

Dr. Oldright then read a paper on the "Disposal of Sewer Gas" (see p. 199), illustrating it by means of diagrams and models. Dr. Playter made some remarks upon the subject, which we were unable to catch; and several queries were put and replied to.

It was then moved by Dr. Carney, seconded by Dr. Stewart and carried unanimously, that the thanks of the Association be tendered to Dr. O'Reilly, of the Toronto General Hospital, for his kindness in throwing it open for the inspection of the members, and expressing their gratification with the general appearance of comfort and cleanliness that pervades the whole institution.

Dr. George Wright then presented the report of the Audit Committee. It stated that the accounts had been examined and were correct, and recommended that the Secretary, Dr. White, be recouped for the preliminary expenses incurred by him in connection with the association. The report was adopted.

The following gentlemen were then appointed delegates to attend the meetings of the British Medical Association and the International Medical Congress, viz.:—Drs. W. Roseburgh, Hamilton, R. A. Reeve, and W. B. Geikie, of Toronto.

The meeting then adjourned until seven o'clock.

#### EVENING SESSION.

The President took the chair at 7.30, and after calling the meeting to order, a resolution was moved by Dr. Oldright, to the effect that in view of the action taken by the medical members of the Ontario Legislature at the last Session, for the purpose of collecting and disseminating information on sanitary matters amongst the inhabitants of this province, and believing that it would be a valuable means of promoting so important an object, therefore be it resolved, that this Association cordially and unanimously endorse the action taken by the medical members of the Legislature, and trust that they will urge as strongly as possible upon the Government during the recess and at the the next meeting of the House the desirability of early legislation which shall make provision for the formation of a Provincial or Central Board of Health, similar to those now long in operation in a number of the neighbouring States, and in many countries of Europe. Carried.

It was moved by Dr. Winstanley, seconded by Dr. Temple, and carried unanimously, that



the sum of \$75 be granted to the Secretary as an annual honorarium.

A paper on the treatment of asthma, was then read by Dr. McKelcan, in the discussion of which many members took part. See page 203.

A paper by Dr. Ryerson, of Toronto, was taken as read in the unavoidable absence of the author.

Dr. Playter called the attention of the meeting to the circular he had just issued to the profession on the subject of phthisis.

Dr. Geikie gave notice that the by-law dealing with the reading of papers be made to provide that no member of the Association shall at any one Annual meeting read more than a single paper, or bring forward more than one subject for discussion.

Votes of thanks were then tendered to Dr. Workman, the retiring President, the various railroad companies, etc., and the meeting adjourned about nine o'clock, to meet in Toronto, on June 1st, 1882.

[We hope to publish the papers and discussions from time to time during the year, and direct attention to the three published in our last issue. Ed.]

#### NEWCASTLE AND TRENT MEDICAL ASSOCIATION.

The Medical Association of this district held its regular meeting at the St. Lawrence Hall, Campbellford, on 8th June. The President, Dr. Burritt, occupied the chair. After reading and adopting the minutes of last meeting, Dr. Byam, Campbellford, presented a patient with

##### HEMIPLEGIA.

An intemperate farmer, aged 35, who was otherwise well and had been in town the previous evening, four weeks ago, felt a numbness over left side, which deepened to complete one-sided palsy, during the day. No known injury although there may have been such. There was no impairment of consciousness at first nor since. He had aphasia for the first five days. The mouth was drawn. He protruded the tongue to the left side. The pupils were equal and not dilated. No ptosis. The left

arm-pit was for the first three days one degree hotter than the right, which was normal. He has dysphagia, which is rather on the increase. He complains that he cannot readily hawk mucus from the throat. There is no cough and no pain. The heart is normal. He has gradually improved under treatment until he can now almost walk alone. The leg has improved most. A discussion arose as to its origin especially whether embolic or apoplectic. The latter opinion prevailed.

##### SCIATICA.

Dr. Byam also presented a man aged 30, who had marked pain in the sciatic region for about eight years and who had been under his treatment for ten months. The treatment had been very various. Results so far were not the most encouraging. He is never free from pain although almost so at times. After a turn of improvement the old pain would return violently and suddenly. The motions of the hip joint are perfect but the pelvis of the side affected is tilted up so as to give the appearance that the limb of that side is shortened. There is a double curve in the spine which is not tender, and this curvature gives the trunk a distorted look when walking which is managed with difficulty. When almost free from pain he walks perfectly, and all deformity disappears to re-appear with recurrence of pain. His sister is similarly affected on the other side, but neither of these have much or any pain. Their common father is undoubtedly rheumatic. The actual cauterization has been well applied over sciatic on two different occasions without relief. The pain is worse at night and is then in the region of the great trochanter. He requires an anodyne twice a day by the hypodermic method. Ether has also been injected. In the ensuing discussion suggestions were made of ammonia baths, nerve stretching, chloroform injections, alkalies and colchicum. Alkalies had been given a fair trial already.

##### FLOATING KIDNEY.

A case of the above was stated by Dr. Byam. The case is still living. The rational and physical signs taken together led to the diagnosis and no other was suggested.

## FATAL HEPATIC COLIC.

Dr. Ruttan, Napanee, presented one large and two small calculi obtained from the following case. Each had rough excrescences. The large was of ovoid shape, its long diameter about five-eighths inch, and shorter two-fifths inch. Mr. H., druggist, aged 40, had been so well that he had never consulted any medical man for eleven years, when present illness began. While in his shop he has often been seen to stop, apply the hand to the right side, while his face was contorted as if in pain which would apparently soon subside. His appetite was good and his general health fair. Between New Year's and the middle of June, he had four or five attacks of hepatic colic. He had a moderate attack on the morning of the first day of his last illness, but went down town, and had an unusually severe one that evening. The pain being referred to the region of liver and back. Vomiting occurred freely but the egesta did not contain bile. Anodynes gave him perfect relief. The first decided relief to pain followed the swallowing of half a teaspoonful of chloroform in water. The matter vomited later, contained bile. He was apparently much better the following day, due to gangrene as was shown *post mortem*. His illness was of only four days' duration. It is believed that a large gallstone obstructed the common duct in the earlier days of illness which sometime before death had escaped into intestines and so allowed of vomiting of bilious matter. Such stone was not found; but the intestines were not searched with care. A calculus was found in the cystic duct and many from the size of a pin's head upward were found in the gall bladder. Nearly the whole duodenum and under surface of liver but especially the liver tissue around the common duct were gangrenous. In such cases Dr. R. would rely on opium, hot baths, chloroform. Dr. Burritt would bleed. He had seen prompt relief from venesection in several cases.

## GALL STONES.

Dr. Hamilton, Port Hope, presented three specimens of gall-stones from three cases. One of them was obtained *post mortem*. The other two were from cases still living. One was the

size of a small pigeon's egg of stony hardness and glistening structure. The patient had died of a disease not at all or very remotely connected with the calculus. A second was the size of a small pea as hard and as pearly white as a tooth. The third was mahogany-coloured, weighed 35 grains, of light density, and presented five facets. A discussion as to their frequency of occurrence and significance ensued.

## OBSTETRICS.

Dr. Bogart, Campbellford, gave details of a case in which there was a double placenta but only one child. There was a single cord which branched, a branch going to each placenta separately. One branch was eight inches long, the other three. He thought care should be exercised in removing the placenta and that such a condition be not overlooked as it might otherwise prove fatal.

Dr. Bell, Peterborough, reported a case in which a midwife had imprudently torn the cord across. Rapid bleeding ensued. Before a doctor could be sent for and brought, eleven miles, the woman was so bloodless as to live only a few minutes after his arrival.

Dr. Burritt reported a consultation case of delivery at full term in which the attending physician is confident no placenta was ever expelled. The membranes seemed certainly to be retained and considerable placental matter was adherent over the usual breadth of surface. There was hour-glass contraction. There was no hemorrhage at all. The child was living. He advised non-interference. A fetid discharge followed for six weeks. The recovery was good.

Dr. Richards, Warkworth, verbally reported a case of apoplexy with stertorous breathing and profound coma.

Dr. Pettigrew, Campbellford, reported a case of congenital absence of brain.

Dr. Ruttan, Napanee, reported a cure of bifid spine by operation, giving particulars of his mode of proceeding. The patient has grown up to sturdy and robust manhood.

Dr. Sinclair, Hastings, reported a case in practice.

Dr. Byam, Campbellford, promised to open a discussion on "leucorrhœa" at next meeting, and Dr. Burritt to give history of a case of uterine hydatid.

The Association then adjourned to meet at Napanee, in October.



## HURON MEDICAL ASSOCIATION.

The regular quarterly meeting of the Huron Medical Association was held in Exeter, on July 5th. Dr. Sloan of Blyth, President, in the chair.

The following members were present: Drs. Sloan, Holmes, Hyndman, Worthington, Gillies, Williams, Irvine, Graham, Campbell, Hurlburt, and Stewart.

Dr. Hyndman exhibited the following cases:

I. A case of extensive necrosis of the femur, in a lad aged 14.

II. A case of necrosis of the humerus, with ankylosis of the right elbow joint, and osseous union of the heads of the ulna and radius, in a boy aged 15.

III. A case of probable disease of the upper cervical spine, in a child aged two years.

IV. A case of long standing contraction and induration of the left lung, in a girl aged 14 years.

Dr. Irving, of Kirkton, showed a very well marked example of infiltrating carcinoma of the right breast, in a woman aged 45.

Dr. Sloan exhibited a young man whose pleural cavity he recently opened for the treatment of an empyema. The operation was performed with strict antiseptic precautions (Listerism.) When he first came under Dr. Sloan's care he had been ill for several weeks and had spat up large quantities of pus, which was due (according to his previous medical attendant in Michigan) to the pus in the pleural cavity finding its way into the lung texture. He soon ceased to spit up pus, and when first seen by Dr. Sloan there was physical evidence of the presence of a large quantity of fluid in the right pleural cavity. The temperature varied from 102 to 103, the pulse was constantly elevated, and the respiration quickened. The introduction of an aspirator needle confirmed what was suspected—an empyæma. Under the spray, Dr. Sloan made a free incision and gave exit to about a pint of sweet-smelling pus. Only three dressings were required. The man increased in weight 40 lbs., and is at present in excellent health.

Drs. Stewart and Hurlburt showed the following cases:

I. A child, aged 19 months, who has lost, in a great measure, the motor power of all extremities. The little patient is unable to stand or even to sit. There is a marked tremor in all muscles brought into action. This tremor is absent when the muscles are at rest. There is also marked loss of the muscular sense. The disease is now of four months' standing, and made its appearance slowly. There has been no elevation of temperature and the child has gained in flesh during the last two months. There are fits of explosive and ceaseless crying. The child had been walking for a period of three months previous to the loss of power.

II. A man, aged 37, who has stenosis of the tricuspid orifice, and disease of the left heart also. When first seen, six weeks ago, he wished to get relief from a severe headache which was constantly troubling him. This headache was much severer when he lay down. So much was this the case that he had to pass many nights sitting on a chair. He has never been what is commonly called a strong man. He, however, never felt or showed any symptoms of his present trouble, until about five or six years ago.

*Present state.*—There is distinct bulging of the cardiac region, and a præ systolic thrill is felt when the hand is laid over these parts. The transverse cardiac dullness reaches (on a line with the fourth rib) from three quarters of an inch beyond the right border of the sternum, to 4 inches to the left—a distance of  $6\frac{1}{4}$  inches. The vertical dullness extends from the fourth rib downwards. A præ systolic murmur (having its maximum intensity over the sternum on a level with the fourth rib) is heard, and a systolic murmur loudest in the mitral area is also heard. The heart's apex is displaced downwards and outwards. There is great fullness of the veins of the face, head, and extremities. There is distinct jugular pulsation. There is great fullness of the retinal veins and the discs are good examples of "choked discs." The pupils are firmly contracted, and resist the mydriatic influence of atrophine to a considerable extent. The atropine, however, quickly paralyzes the accommodation.

There is no œdema of the extremities, and the urine is free from albumen. The pulse is

generally about 60, and regular. Tracings taken from the radial and jugular were shown. For the last three weeks he has been taking full doses of Calabar Bean, with the object of relieving the full veins, and headache caused thereby. It was, however, found not to act so beneficially as Digitalis which was previously prescribed.

III. A case of *Splenic Leucocythæmia*. The patient, a man, aged 47, had intermittent fever for nine months, sixteen years ago, in Tennessee. Three years ago he felt weak and had palpitation of the heart. It was only ten months ago that he first noticed "a lump" in his left side. It rapidly increased in size until six weeks ago, since which it has diminished somewhat.

During the months of April and May of the present year, he has had daily attacks of chills, fever, and sweating. When first seen (1st June), his temperature was constantly elevated ( $100^{\circ}$  to  $101^{\circ}$ .)

*Present state.*—The spleen extends from the sixth rib to within two inches of the ilium in the mamillary line, a distance of  $7\frac{1}{2}$  inches. In a transverse direction from one inch to the right of the umbilicus to within four inches of the spinal column, a distance of  $11\frac{1}{2}$  inches, there is no abdominal pain or tenderness. The liver extends two finger breadths below the ribs.

There is no enlargement of any of the lymphatic glands, nor is there any tenderness of any of the bones. Blood: 2,500,000 red cells in a c.m.m., and 147,000 white, being a proportion of 1:17. The red cells vary in size considerably, as also do the white. Many of the latter are very granular, and a good deal of free granular matter is to be seen.

He sleeps well. The appetite is good and the bowels are regular. Only on one occasion has he had epistaxis. There is a considerable amount of cedema of the lower extremities. About six weeks ago he commenced taking arsenic and quinine. There is no elevation of temperature now, and he has gained ten pounds in weight. The spleen has also diminished in size, but there is no improvement in the state of the blood.

Dr. Stewart and Hurlburt showed also the following microscopical preparations:—

- I. Spleen and liver from a case of leucocythæmia.
- II. Spleen from intermittent fever.
- III. Melanæmia of the brain.
- IV. Simple hyperæmia of the brain.
- V. Tuberculosis of the pericardium.

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### Miscellaneous.

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The Cincinnati *Lancet and Clinic* explains how this is thus: "Oh! Bliss! What Bliss is this? Is this Cundurango Bliss? Yes, this is Cundurango Bliss. How did Cundurango Bliss come to this? About like this: When the President fell he turned immediately to Bliss, and oblivious at once of the extreme agony he felt, suppressing at the same time the shock of the peritoneal wound, he exclaimed, 'Bliss, my boy, you have known me from my boyhood. Bliss, take care of me.' And this is how Bliss came to this. The report that peritonitis has been averted and granulation of the wound promoted by the administration of this Bliss's cundurango, lacks confirmation. As to precisely what is being done for the President we are as yet in blissful ignorance. But when ignorance is bliss 'tis folly to be wise."—*Mich. Med. News*.

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CONUNDRUM—Why did only four members of the Ontario Medical Council vote against Dr. Bray's "inexpensive method" of licensing a Homœopathist, instead of "admitting him to registration in the usual way—by undergoing the usual examinations?" Everybody gives it up.

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### Births, Marriages, and Deaths.

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#### BIRTH.

At Stouffville, on July 17th, the wife of W. J. Wilson, M.D., of a daughter, still born.

#### DEATH.

At Brampton, July 19th, James Alexander, second son of Dr. Patullo, aged 20 years.



# THE Canadian Journal of Medical Science.

A MONTHLY JOURNAL OF MEDICAL SCIENCE, CRITICISM, AND NEWS.

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TORONTO, SEPTEMBER, 1881.

## Original Communications.

### GENERAL PARESIS.

*An Extract from the Report on Medicine to the  
Canada Medical Association Meeting, held  
at Halifax, N. S., August 3rd, 1881.*

BY A. P. REID, M.D., L.R.C.S.E., ETC.

Superintendent of Nova Scotia Hospital for Insane.

MR. PRESIDENT AND GENTLEMEN.—\* \* \* \* \*

Of late there are indications that the sphere of neuro-pathology is being so extended as to include many maladies that were considered beyond its bounds, and there is reason for it, because, either a neurotic tendency prevails much more than formerly, or it has been more carefully worked out. To me it appears that many diseases assume a neurotic character, much in the same way that, in malarial districts, malaria imposes itself on other forms of disease. Owing to more extended educational facilities, the restless energy that pervades all classes of society produces a tax on the nervous or mental part of our organization which our fathers did not experience. In the race for *wealth*, they were content to slowly and surely follow the well-known paths, and in the race for *fame*, they were satisfied if it came after their labors were accomplished. They had more of the *otium cum dignitate*, while performing a vast amount of work and original research; but it may be also said, they had fewer competitors than we of to-day. Bearing these things in mind, it is not to be wondered at if the nervous organization becomes more excitable, and modifies pathological indications by a neurotic tendency, or that we should have a

development of maladies similar to what are termed the neuroses.

There is one form of disease of the brain, first described by Esquirol, and more fully by Bayle, in 1822, which is becoming more and more prevalent, and invariably gravitates to the Hospital for Insane. It is rarely, if ever diagnosed by the ordinary medical attendant, unless as a case of disease classed under that very general term *insanity*; and I trust this will be my excuse for importing a specialty into a general discussion on medicine. I refer to the so-called *Paresis*, or *General Paralysis of the Insane*, names not only indefinite, but in their ordinary acceptance misleading.

This malady is unknown amongst savages, very rare in the colored races, and seldom attacks females. Its most common victims are men in the prime of life, who are engaged in some form of business, and very often the able, intelligent, and energetic. It is not, so far as known, hereditary, in this way differing from insanity in general which has heredity as a most common cause. Thus far a clear case of recovery is questionable, and it runs a rapid course of from one to four years.

If this *opprobrium medicince* is ever to be satisfactorily dealt with, it must be by members of the general profession, because with them alone is the probability of its detection at a stage, which may be so early as to admit of cure before the arachnitis and microscopic organic lesions of the brain and spinal cord have so far developed as to be intractable, a condition always assumed before the symptoms of mania and pronounced insanity present themselves; so far all these patients become insane

before application is made for their admission to the Hospital for Insane.

If it would not trespass too much on your time, I would rapidly run over the more prominent indications at the commencement.

The first symptom likely to be marked is an alteration in the patient's manner and habits, which may be noted by those familiar with him. This is likely to be a precursor in any form of insanity, but in the *paralytic* form it is nearly always shewn by extravagance in acts, expenditure of money, presents, or assertions, and there is a silliness about the acts not seen with ordinary maniacs or melancholics, who can, and often do, reason and argue sharply, although, mayhap delusionally.

The *paretic* or *paralytic* (similar terms) has no shrewd argument in favor of his outrageous acts. He may expose his person, half unconscious of what he is about, or assault women without regard to place, opportunity, or consequences. He is regardless of appointments, of meals, of bedtime, &c. ; comes and goes scarcely noticing those about him ; gives conflicting and absurd orders to servants and others, and rages with passion if they be not executed on the instant. There is a want of plan and method in his madness.

A most important symptom is forgetfulness. He forgets anything and everything—this is observable in many ways ; he is also apathetic and indifferent, or careless about that which formerly interested him. When he takes up new schemes his attention soon flags, and his interest vanishes. There is, in short, in his whole manner weakening of mind, not unlike senile dementia, and this occurring in a vigorous man of, say 35, indicates the mental ruin to follow.

Sometimes in the early stages, he is dull, sulky, less frequently depressed and melancholic, but careless of all, save the idea of the moment. He gets into a violent rage when remonstrated with, or thwarted, he sleeps badly, eats and drinks irregularly, perhaps voraciously from inattention and forgetfulness of what he has taken. He spills his food on his dress, eating in careless haste ; is neglectful of person and appearance, often dressing in incongruous garb. By degrees his condition merges into

excitement, and with necessary opposition, or interference, the mental alteration becomes manifest insanity.

In this first stage which may continue for a few weeks, or, perhaps, a month or two (never longer, as this is a progressive malady), he is rarely seen by a specialist. The family physician may be consulted, and puzzled to explain a sickness with no well-marked functional disorder—the patient meanwhile drifting into the second stage, or that of *mania*.

The mania in the vast majority is accompanied by delusions of importance, riches, strength, or endurance. The delusional ideas are not fixed, and he will not try to defend them.

If the melancholic tendency presents itself, it also differs by its incongruousness from other forms of melancholia, as his grandiose notions are unlike the delusions of other forms of insanity. He is perfectly at home with his surroundings, feels exquisitely happy, and perfectly contented with himself.

The paralytic symptoms gradually begin to show themselves : defective articulation, tremor of the tongue, dropping letters or words in his spelling, or writing, or conversation, inequality of pupils, and defective progression, or shambling unsteady walk are the more prominent indications.

Epileptoid fits, more or less severe, show themselves during the course of the disease, and not unfrequently life is terminated by a series of severe convulsions.

The ordinary sequences, are imbecility and general enervation, the debility lasting for a varying period, before death relieves the sufferer. In the majority of cases, at the latter part of the disease, it is impossible to conceive of a human being more thoroughly fallen from "his high estate." He is without sense or reason, emaciated and unclean in the extreme. He slowly dies a lingering, unconscious death, without a last glimmer of intelligence to cheer his friends.

There are many other distinctive symptoms which show themselves during residence in the hospital, but it would be rather out of place to discuss a subject here that only presents itself to the few who devote attention to the speciality.



My chief object in the introduction of this form of brain disease is, if possible, to call attention to a malady of a most serious character, which is on the increase, and which so far has not received the recognition in general practice, or in works or lectures on the practice of medicine that it is entitled to; partly, no doubt, from the obscurity of the primary symptoms, and, mayhap, partly from the minds of physicians not being particularly directed to its manifestations.

Though this short paper cannot be considered of any scientific value, when reported on by the broadest and most kindly critic, yet it may be of some service, if even in one case, it may arrest the attention of a physician when consulted by friends (never by the patient) about a gentleman who has shown of late an alteration in his manner, from prudence to lavishness, from morality to lasciviousness, and this without the exercise of even ordinary prudence or judgment; who, methodical and careful, becomes careless and prodigal and overbearing in manner, and to this adds forgetfulness of recent sayings or doings while carrying on his ordinary avocations.

A physician, who in a puzzling case, can make out a history similar to the above, would be justified in giving a prognosis of the tenor within indicated, and if he have the confidence of the patient, he could indite a plan of treatment, which few, if any of us have ever had the opportunity to essay. He could trace out a path not attempted by a predecessor, and returning (do what is considered almost impossible), give to us something new in the practice of medicine.

## LEPROSY IN CAPE BRETON, NOVA SCOTIA.

BY A. MCPHEDRAN, M.B., TORONTO.

I am indebted to the kindness of Mr. Wm. Fletcher, B.A., undergraduate in medicine, for the following full and interesting history of leprosy in the Island of Cape Breton, N.S., together with the details of a case that came under his observation.

In Victoria County, between the Middle and Margaree Rivers, surrounded by steep

felsitic, limestone, gypsum, and conglomerate hills of about one thousand feet in height, is situate the chain of three small lakes O'Law, weirdly beautiful among the highland scenery, and unsurpassable in romantic charm. Rivulets of clear cold water course down the hillsides every few yards; but here, too, the snow sometimes lies till June, and cold mists hang thickly through the summer and autumn nights. The inhabitants, a vigorous farming community, are of Irish descent with an admixture of Highland Scotch. Their habits are simple, rising and retiring with the daylight; their houses heated with stoves and the old-time hearth; their diet, as in other parts of the island, is of fish, potatoes, oatmeal, flour, beef, mutton, tea, and milk.

Justin McCarthy, of Lake O'Law, farmer, was born in Newfoundland, in 1794, of Irish parentage. When still young he moved to Cape Breton, settling finally in Lake O'Law shortly after his marriage, in 1836, with Betsy Hardy, of Prince Edward Island, a native of Lincolnshire, England. In the year 1852, this Betsy McCarthy became affected with a disease the symptoms of which, as described by the neighbours, in many accounts precisely correspond to those given in the case of James Cameron. Large numbers of the inhabitants of this and other portions of the island saw this case as well as the others about to be mentioned, from time to time; and the local medical men, and parish priest who had been a resident in Tracadie, N.B., where leprosy exists, pronounced the disease to be leprosy. Betsy McCarthy died in 1864, after an illness of twelve years. There is no history of any disease in Justin McCarthy's family, and he himself still enjoys the best of health and has all his faculties unaffected. They had children, five boys and three girls, the course of whose lives were as follows:—

Richard, died from disease, after twenty years' illness: left a family of six, all of whom are well.

John, died after twelve years' illness. Married Peggy Cameron, sister of James Cameron, by whom he had three children, all well. Peggy herself said to be hoarse.

Mike, died after being ill ten or twelve

years. James Cameron used to sleep with him.

William, died at twenty-one. Joseph Brown washed and laid him out.

Henry, living and in good health, as is all his family.

Mary, married John Doyle, died at thirty-eight, after an illness of twenty years. John Doyle died after being ill six years. No relationship. Two daughters died of same disease; five others living and well.

Susannah, married James Cameron. She is perfectly well and vigorous, as are her two children. No blood relationship between her and her husband.

Kitty, married John O'Connor, and has a large family, all well.

There is no well-marked case in the district of Lake O'Law at present, two reported cases proving on investigation spurious. Joseph Brown, late of Lake O'Law, farmer, of Irish parentage, with no blood relationship to the McCarthy family, is said to have attended on William McCarthy during part of his illness, and to have washed and laid him out on death. Shortly after this he was attacked with symptoms similar to those of the other cases, and died after an illness of four or five years. His wife and three children living and well. The people look upon the disease as contagious and are very much afraid of it, so much so that the charitably-disposed have been in the habit of aiding the Cameron family by leaving their offerings in a barrel placed at the roadside.

CASE, 9th May, 1881.—James Cameron, aged forty, farmer, on the French Mountain between the Big Intervale, north-east Margaree and Cheticamp, Inverness County, Cape Breton, born in Grand Mira, C.B. Married, in 1866, Susannah McCarthy, daughter of Justin McCarthy, referred to in above history, by whom he had two children, girls, aged respectively thirteen and twelve, both the picture of health. His father, also a farmer, came from the western isles of Scotland to Judique, C.B., where he died of old age; his mother, a native of the Highlands of Scotland, is still alive and well. There is no history of any disease in either father's or mother's family. He has one

brother and four sisters, all enjoying good health, as the subject of this notice himself did till the appearance of the first symptoms of present illness in June, 1870. In March of that year he cut his foot, losing much blood. During the time the wound was healing he used to sit out on the ground in the sun, when he thinks he caught cold, although he had no symptoms of such at the time that he can remember. He was in the habit of sleeping with Mike McCarthy, of Lake O'Law, who is reported to have died of leprosy, some two or three months before the latter's death.

The disease from which he suffers commenced with a change in the quality of the voice, which became hoarse and croaking. Then closely followed heaviness, swelling, stiffness, and shooting pains in the face, hands, forearms, and feet and legs. Shortly afterwards blotches of a brown and purple colour, and tumors of sizes varying from a pea to a pigeon's egg, made their appearance, more particularly in the parts above indicated, and not so numerous on the body. The tumors remained much in the same condition for three or four years, some of them spreading in extent and disappearing; others, especially in the feet, breaking and discharging a yellowish green badly-smelling matter. Some of these latter have since healed up, while others again, as at the ends of the fingers and toes, still continue to run.

Six years ago the eyes became weak, congested, and very irritable, with a constant flow of lachrymal secretion over the cheeks. A film formed over the left eye and shortly afterwards over the right, and in the course of a year his sight was completely lost. His nose, first affected in 1875, swelled at the extremity and afterwards ulcerated, the point dropping off, leaving a depression in its place. For nine years his throat has been swollen and sore, although not very troublesome till the last two years, during which, on swallowing, crumbs seem to stop in a hole which he believes to be in it. His bowels are irregular, three days sometimes elapsing between stools; and at such times, though he drinks copiously, the urine is scanty and high-colored. He eats but one meal a day, and that when he is hungry. Sleep is



taken only during a few hours in the morning, and this from habit, not because of any particular disturbance during the night. Sores appeared on the penis and scrotum, but healed up entirely about seven months ago. For the last three weeks he has been complaining of a dull continuous pain in the neighbourhood of two hard, immovable, rounded nodes, on the second and third ribs at their junction with the sternum: they are not tender on pressure. He has been unable to walk during the last two years, most of which time he has spent in bed, although he can easily and does sit up.

*Present condition.*—When first seen he was lying on his back, with a thick yellowish-whiteropy mucous dribbling from his mouth, the mucous membrane of which is thickened and roughened, as is also that of his tongue. The sense of taste is nearly wholly lost. The integument of the face is harsh, tense, glazed, brownish-yellow, with purple spots, and thickened especially over the superciliary ridges, malar bones, and lips, giving the face a very morose expression. The eyelids are wide open and everted; the conjunctiva intensely congested and thickened, with a portion roughly corresponding in shape and position to the cornea, elevated about one-eighth of an inch above the surrounding surface. No remains of either iris or pupil are to be seen. The septum nasi is visible for about a quarter of an inch, the point and alae of the nose being destroyed to that extent. The sense of smell is wholly lost. Scales of dark-brown colour, surrounded by a purple deeper zone and superficial zone of white flakes, some of which are as large as herring scales, fleck the face, on which are also small hard immovable tumors and purple puckered cicatrices. Only a few thin straggling hairs are to be seen beneath the chin,—his eyebrows, eyelashes, whiskers, and the hair above the forehead having all fallen out.

The integument of all the extremities presents similar appearance to that of the face, like nodes and cicatrices being noticeable. On the right ulnar styloid process is a punched-out ulcer one inch in diameter, with raised purple

edges, discharging a small amount of greenish ichorous pus, with a foul gangrenous odor. Similar ulcers occur on the back of the hands. The fingers have lost the nails and portions of the terminal phalanges, the stumps being intensely congested, with the bone projecting in the case of one or two. The toes are in a similar state. Owing to this condition of the hands, and to the fact that general sensibility is greatly diminished, he is unable to use his hands for anything save large objects. All the movements are awkward. The chest is somewhat emphysematous; breathing slow and laboured. The intelligence is clear, temper irritable and desponding, sleep disturbed. Speaks in a hoarse croaking voice, and that only after a deep inspiration. Pulse very fair.

The foregoing are the notes almost in full. There is no doubt but that the disease is the tubercular form of elephantiasis Graecorum. It was with no little difficulty that Mr. Fletcher obtained the information. The people in some cases being able to speak only Gaelic, he had to pursue his investigations by the aid of an interpreter. The chief point of interest in these is their etiology. It is to be regretted that a more full account of the early history of Betsy McCarthy could not be obtained, as to whether she was in any way exposed to the leprous contagion, if such there be, prior to her removal to Cape Breton. Mr. Fletcher may perhaps be able to obtain further information on this and other matters connected with the cases at some future time.

Tilbury Fox, in discussing the manner in which leprosy is propagated, quotes from the Leprosy Reports of 1867, of the College of Physicians, that "all but unanimous conviction of the most experienced observers in different parts of the world is quite opposed to the belief that leprosy is communicated by proximity or contact." But he himself is a strenuous advocate of the contagion theory, as well as of that of hereditary transmission, and in support of his views instances the history of leprosy in Madagascar and in the Sandwich Islands. In the former, while those affected were excluded from society, leprosy was kept within bounds; but the law of exclusion having fallen into dis-

use the disease spread to almost an incredible degree. This was doubtless largely due to the lepers being allowed to marry without hindrance, but the natives were convinced of its contagiousness. In the Sandwich Islands leprosy was unknown before 1848 at earliest, at which time it was supposed to have been brought by the Chinese. A recent census places the number of lepers at 250, or about 2½ per thousand of the natives, and during this time the hygienic state of the people has improved. On the other hand Kaposi, in "Hebra on Diseases of the Skin," as emphatically declines to acknowledge the contagiousness of leprosy, and does not attach much importance to hereditary transmission. He quotes Viichow to the effect that the term hereditary can only be taken in the sense of a predisposition to leprosy, just as a predisposition to tuberculosis is generally considered hereditary, the development of the disease being dependent on certain external causes. He sums up thus: "It would, for the present, seem not unreasonable to suppose that certain physical and geographical peculiarities of particular countries serve as etiological influences in the production of the primary disease, whilst its propagation, when once developed, is more or less aided by hereditary predisposition."

These Cape Breton cases throw no light on the primary cause of leprosy, as there is nothing either in the climate or "physical and geographical peculiarities" of the island, or in the habits of the people, differing materially from many other sections of Canada. Nor does the contagion theory receive much support unless, indeed, the disease found the climate and "physical and geographical peculiarities" of the island very uncongenial soil, and the contagious principle has been sufficiently potent to overcome in some degree these obstacles. But hereditary predisposition seems to have been the most marked factor in the propagation of these cases, seeing that of the whole eleven cases eight were hereditary. Dr. Hyde, of Chicago, gives a case coming under his notice of hereditary transmission in a child, born in the United States; the father, who came from Sweden, was leprosy.

WILTON AVENUE, *Toronto*.

## ELEPHANTIASIS.

BY T. T. S. HARRISON, M.D., SELKIRK, ONT.

[Read before the Ontario Medical Association.]

This case which I bring before you with some doubt and hesitation, I have called elephantiasis. It has this characteristic of that disease, that the affected limb is enormously enlarged. It differs, however, from the typical elephantiasis in the absence of the thickened, indurated tuberculated and cracked integument.

Patient, aged 20, Canadian, born of German parents. Parents, and brothers and sisters, healthy; the mother's family consumptive; the maternal grandmother died of cancer.

J. A., at birth was healthy; a very large, fine child. At the age of two and a half his mother noticed that one leg was growing faster than the other. I first saw the boy when about three years of age. I then found the left leg decidedly the longer. The right was normal in contour, while the left was not only longer, but larger and abnormal in shape; the skin hung loosely and it had a soft, doughy feel, was largest at the ankle, and had no bulge or projection at the calf. I gave the opinion that there was arrest of growth in the right leg, but had to say that the left had some peculiar affection of the soft tissues at least. The mother said that other medical men had given the same opinion. The child was merely treated for his general health.

I saw the child occasionally as I attended other members of the family, for several years. The size and length of the limb increased so rapidly, that there was soon no doubt as to the abnormal growth of the tibia and fibula.

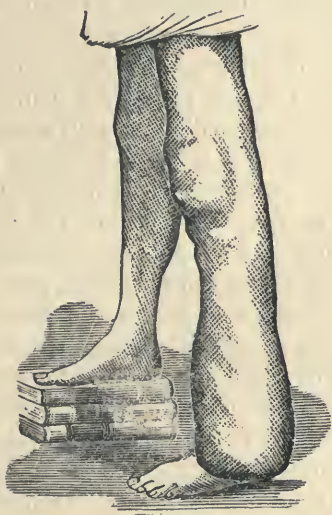
Some seven years ago, when about thirteen, I exhibited the boy at the meeting of the County of Haldimand Medical Association. At this time, the disease, which at first was confined to the leg, had invaded the thigh; there was enlargement above the knee, and the femur was some three-quarters of an inch longer than its fellow. The patella was broader, thinner, and flatter than natural.

Then the entire limb was, I think, nearly or quite five inches longer than the right. The weight of opinion was against surgical interference, though amputation, resection of



the bones of the leg, ligation of the femoral artery, division of the nerves, etc., were mentioned. For some years, until he was about eighteen, the deformity increased, but the mother thinks it is now stationary; she, at least, has not had to increase the size of his stockings since that period.

You see the state of the limb to-day. The enlargement has extended up the thigh. The femur is nearly two inches longer than its fellow. The circumference above the knee is four inches greater than that of the right, while the circumference at the ankle is 13 inches greater than that of its fellow (the right leg,  $8\frac{1}{2}$ , left,  $21\frac{1}{2}$  inches.) This size (at the ankle) would be increased, were he to keep



long on his feet, and diminished after his night's rest.

In the cut you will observe the right foot rests on some books. These, though they do not bring it to a level, are  $5\frac{7}{8}$  (five and seven-eighths) inches high. The femur is bowed, so as to take nearly, or quite an inch off its length. It is increased in size and altered in shape, the spine at the shin entirely absent. The skin is soft, and with the tissues it covers, has a soft, flabby feel. The hairs on the affected parts are very much elongated, the skin in places dark coloured, and the inguinal glands on both sides greatly enlarged. The eyes are rather prominent, and show a large amount of peculiarly white and glistening sclerotic.

The boy works on a farm, and though he tires rather easily, has never been seriously ill. It has been suggested that it might be of syphilitic origin. His parents are very quiet farmers, who, from extreme youth, have always resided in a rural township, where it would be almost impossible to find a case of syphilis in a generation. They never visit towns or cities, and I should feel safe in saying that if syphilis is a factor in the case it was contracted as far back as the grand parents of the patient.

DISCUSSION.—Dr. A. A. Riddel remarked that he had probably seen as many cases of elephantiasis as any other member of the Society. It was much more prevalent in hot than in cold climates. To him it seemed that the case exhibited by Dr. Harrison lacked some of the principal features—such as the thickened, hard, rugose, and anæsthetic skin—of true elephantiasis. He had never seen or heard of a case in which such increase of the length of some of the long bones as was here present had been observed.

Dr. Hamilton said that it did not at all correspond with the few cases of elephantiasis he had observed. In all of these the limb was of almost wooden hardness, while here there was the feeling of a soft doughy bag. What is elephantiasis? It consists chiefly in hypertrophy of connective tissue, and was of fibrous nature and consistence, the very opposite of that presented here. Besides anything like elephantiasis could not from its nature disappear on simple elevation of the limb as this was stated to do to a considerable extent. This favored the view that the lesion was in the softer parts. If the child must be named something he would have it christened Lymphangioma, or an enlargement consisting mainly in dilatation of the lymph channels—a clinical entity concerning which the literature was scanty, and the only thing written of late was by Dr. Busey, of Washington, who had written\* a small work on the congenital forms. He thought its general symptoms, history, and behaviour upon elevation corresponded with this view.

\* Dr. Busey's case lxxxvii, was strikingly like the one presented. See cut in *American Journal of Obstetrics* for January 1878, p. 99.

Dr. Oldright remarked that there was an elongation of the bone, and that the most prominent feature was not a hyperplasia of the areolar tissue such as we have in elephantiasis.

Dr. Teskey looked upon the case as one of elephantiasis. Although it lacked many of the conditions generally found in that disease, yet those which were absent were chiefly the accessory rather than the essential ones, as, for example, the warty growths of the skin; while those conditions which are essential to that disease, *e. g.* the progressive hypertrophy of the cellular tissue, were present to a marked degree.

Dr. Temple had considerable experience of elephantiasis in India, but could not reconcile the peculiar conditions presented by this case with what he had before observed. The rapid emptying of the limb by elevation was not characteristic of elephantiasis. The sensation impressed upon the fingers by these tissues was also entirely different.

Dr. Graham did not think that the case was one of elephantiasis. He considered the condition of the bones to be one of hypertrophy, perhaps caused by some trophic nerve lesion and the same might be said of the connective tissue. There was also present a peculiar condition of the lymphatics which he could not explain. He had observed the same condition present in a patient under his care in the Toronto General Hospital, in whom the thigh had the same feeling resembling a bag of worms. This might be caused by enlarged lymphatic ducts.

Dr. Sheard said that he regarded the case as one of elephantiasis, admitting that there was not so much hardness as is *usually* found in elephantiasis. He remembered three cases where the softening was as marked as in this one, and yet hardening occurred subsequently. As to the pathology of elephantiasis it was known to be mainly modified nutrition and he could easily understand how that, where there was a change in nutrition producing hyperplasia of the fibrous connective tissue elements, there could also be produced at the same time an increase in the bony tissue leading to lengthening

of the limb. He would suggest that the elastic bandage be tried, believing that the artificial pressure supplied by the elastic band would, in a measure, supply the lost vascular tone, diminish the amount of blood sent to the parts and hence arrest the hypertrophy. He had seen a somewhat similar case in an (East) Indian lad treated in this way with most satisfactory results.

Dr. Cameron would hesitate to call the condition elephantiasis, although at a distance it resembled it very closely. Upon manipulation, however, a very different impression was conveyed. He pointed out the greatly enlarged inguinal glands, and admitted a condition of lymphangiectasis but could not regard this as the cause of the elongation of the limb since the lymph channels on the opposite side and especially the glands were almost equally enlarged and had not produced a similar condition of the corresponding limb. He was rather inclined to regard it as a result of trophic nerve lesion analogous to the unilateral hypertrophy of the face, so well described by Jonathan Hutchinson, and others, the counterpart of the more common unilateral atrophy. This view he thought received corroboration from the presence of certain pigmentary patches on that buttock and on the inside of the leg of the affected side. With reference to palliative treatment, he thought the suggestion of the rubber bandage to be certainly a good one. But with regard to more radical relief of the condition, he thought the time had gone by for anything short of a serious operation. Had the sciatic nerve been stretched or divided in the early history of the case it might have proved of service, as had been shown by Morton, of Philadelphia. As it was, two operations only suggested themselves as applicable, *viz.*:—Osteotomy, such as MacEwan, of Glasgow, would probably practise, or amputation.

Dr. Osler said, that notwithstanding the somewhat unusual flabbiness and softness of the tissues to the touch he would incline to regard it as elephantiasis. This consisted, undoubtedly, in hyperplasia of the skin and subcutaneous connective tissue, and he could conceive of an hypertrophy of the bone resulting from the same causes.



## LIVING EXAMPLE OF LYMPHATIC DISEASE.

We select the following as companion with Dr. Hamilton's case.  
—Ed.]

Mr. Walter Whitehead, at Manchester Medical Society, (reported in *British Medical Journal*), showed a female patient, aged 15, suffering from lymphatic œdema and giant-growth of her left leg. The symmetry of her two legs had been maintained up to the age of twelve, when she commenced working in a factory as a "half-timer." She then noticed for the first time that the left leg gradually became larger. The swelling increased during the day, but subsided very considerably during the night. The development became more marked, when she extended the hours of attendance at the mill. No accident nor injury could be remembered, and there was an entire absence of pain from the commencement. There had never been any inflammation nor hyperplastic changes in the integuments, nor any impairment of sensibility or muscular power in the limb. At the age of fourteen, a lymphatic fistula opened above the inner condyle, and periodically discharged about half a pint of fluid in the twenty-four hours. The leg ultimately acquired an increase of about three inches more than the right, measuring from ankle to hip; from patella to malleolus, it exceeded the right by one inch; and the foot was three-quarters of an inch longer than its fellow. Elevation of the leg and continued elastic pressure caused all the swelling to disappear; to return, however, when these measures were relaxed. The skin of the leg was uniformly pale, firm, and elastic, with the exception of a small area just above the outer malleolus, where there was a slight hardness of skin, superficial œdema, and pitting. There was no manifest impediment to the venous circulation, or apparent glandular induration. From the foregoing, he regarded the case as one of those where probably some congenital structural defects in the lymphatic trunks remain indefinitely passive in the absence of any immoderate influence, but which, when overtaxed mechanically, break down. He believed that it was one of a class recognized under the generic term of elephantiasis, but characterized by the deep rather than the superficial lymphatics being at fault, and where the lymphatic

trunks were in a condition of dilatation, and with incompetent valves; and where, probably, there was also a consecutive dilated condition of the lymph-spaces.

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ANEURISM OF SUBCLAVIAN COMPRESSED BY ADHESIVE STRAPS AND ELASTIC BANDAGE.

BY DR. COBURN, OSHAWA.

[Reported before the Ontario Medical Association.]

MR. PRESIDENT,—Since entering the hall this evening I have learned that my name appears upon the Programme for a paper upon the subject of "Aneurisms." Evidently there has been some misunderstanding upon the matter, as it was not my intention to submit a paper, but to present a patient, and I had hoped, in accordance with the arrangements I had made, to have been able to bring the patient before the Association at this session, but for some reason, which I cannot at present explain, the patient did not meet me at the station this afternoon, on my way here, as I expected he would. I hope, however, to see him arrive by the early morning train to-morrow. While making this explanation I may as well, perhaps, give a brief history of the case, and, at the same time make some allusion to the plan of treatment.

The wife of the patient referred to called at my office on the 25th of March last, and stated that her husband had not been feeling very well for some time, that he experienced more or less pain in the right shoulder and in the upper part of the right arm, that he did not eat nor rest as well as he usually had done, that a few days before her visit he had accidentally observed a "lump," as large as a hen's egg, near the side of the neck, in the hollow below the shirt-band, that the lump was not to say painful or very hard, that it was not discolored, and for the reasons mentioned did not appear like a gathering. As the patient's work was urgent, and he was engaged every day, and thinking I might decide to prescribe without making a visit, the history of the case was detailed somewhat minutely, more particularly the points first mentioned. The kind of work her husband was engaged at, the location of the lump and its physical peculiarities, suggested

that, in order to a proper comprehension of the case, a visit was necessary. I accordingly saw the patient that evening, and heard from him a recapitulation of the history given by his wife. The "lump" I found to be situated over the second part of the right subclavian, in the angle or fossa at the side and lower part of the neck. It was nearly oval—the base pointed downwards, forwards, and outwards. Its greatest measure, from base to apex, over its convexity, I found to be two and a half inches, its oblique measure two and a quarter inches, and its shortest one and three-quarter inches. Its pulsations and murmurs were synchronous with the cardiac systole, and the reflex pulse-wave was toward the mesial line and upwards. Not having a hypodermic syringe with me at this visit, I was unable to determine the nature of the contents of the lump, which had been so very well described to me, consequently I decided to make a second visit at an early date. I accordingly saw the patient again two days later, and after going over the case once more, I made the hypodermic test, and found that the lump contained arterial blood. I then decided to make an effort towards reduction by compression. The mode adopted has been by adhesive straps drawn tightly over a firm, closely-fitting compress. Finding these did not accomplish all that was desired, graduated pressure has been affected recently, by an elastic band applied over the straps. What degree of success has been secured you will be better able to determine upon personal examination of the patient.

When first examined the pulsations of the sac were somewhat diffused, and difficult to trace, but after a time, as it became smaller, they were more easily detected, and the *bruit* much more distinctly heard. The diagnosis was aneurism of the thyroid axis, at or about the origin of the transversalis colli and, supra-scapular arteries, involving, as nearly as could be determined, both these branches. The aneurism was caused doubtless by prolonged severe muscular exertion in the use of a heavy hammer. The adhesive straps were removed at intervals of from two to three weeks, and fresh ones applied. Improvement was specially noticeable after the application of the elastic band, and at present (August 6th) I am glad to be able to report almost complete obliteration of the sac.

## Selections: Medicine.

### THE USE OF LOCAL REMEDIES IN THE TREATMENT OF DIPHTHERIA.

WE recently asked a certain number of physicians, whose experience on the subject seemed especially to entitle them to speak, to favour us with their opinion on the advisability of using local remedies in diphtheria, and to state what drug they preferred to use. The subject is one which is to be discussed at the approaching meeting of the International Medical Congress; and we trust that the paragraphs which here follow may stimulate the interest of our readers in what will, no doubt, be a most interesting debate. There are many difficulties surrounding the subject, and one of these has been forcibly put by Dr. OCTAVIUS STURGES, who writes thus:

"I have never been able to convince myself of the value of local remedies in diphtheria. In cases that have been occurring lately, there has been so large a proportion of recoveries, especially after tracheotomy, that the question of treatment, local or otherwise, or any comparison between the results now and two years ago, or, still more, eighteen years ago, is hedged about with difficulty. My personal belief is, that the great safety in diphtheria is early tracheotomy; and the important question, awaiting authoritative statement, in reference to the disease, the precise clinical signs which give the proper signal for the operation."

Sir William Jenner, who published (now many years ago) a small monograph on the disease, advised the use of local remedies, preferring nitrate of silver for this purpose. There are still many who adhere to this plan, and for these Dr. EDWARD WOAKES may be allowed to speak. He says:

"During an experience of diphtheria in one locality, where the disease was rife, dating from 1860 to 1876, and which included some four or five distinct outbreaks of the disease, I invariably used topical remedies. I do not recall a single fatal case in which the following plan was adopted, providing the larynx and air-passages proper escaped—though nearly every instance in which those organs were implicated



ended fatally. The disease presented itself in two forms: the catarrhal and the membranous, though a tendency was observed for the former to pass into the latter, especially in the late stages of the disease. In the catarrhal type, I contented myself with syringing the nasal passages, and swabbing the fauces with a strong solution of chlorinated soda, repeated very frequently, every hour or two. In the membranous phase, I adopted the local application of nitrate of silver, almost invariably in the solid form. This I use very freely, stirring it into, and, if possible, under the exuded mass, completely breaking up the latter, so as to reach the diseased surface beneath. In very bad cases, I have made this application as often as three times in one day, so as to keep pace with the renewal and extension of the patches. In addition, I give repeated mouth and nose washes of chlorine or permanganate, in order at once to disinfect and get rid of *débris*. The form of query does not embrace internal treatment; but, as I always push perchloride of iron to the limit of toleration, the passage of it over the diseased mucous tract must, in some degree, be regarded as a topical application. Up to the present time, I have met with no treatment that offers greater advantages than the above, and its severity may be mitigated by the concomitant local application of morphia in powder, by means of the insufflator; and I confess, at the risk of appearing obsolete, to a preference for that method which has so often stood me in good stead."

Professor McCALL ANDERSON, on the other hand writes to us, that "he is entirely opposed to the use of caustics and other strong applications in cases of diphtheria, as being injurious as well as increasing the distress of the patient." But, he adds, that "he has great faith in the local application of carbolic acid, of the strength of two or three grains to the ounce of water, and to which one drachm of glycerine has been added. This may be used in the shape of spray; or a large mouthful may be taken frequently, and allowed to lie for a short time at the back of the throat without gargling."

Dr. ROBERT CORY also expresses a similar opinion. "I believe," he says, "the use of topical applications is advantageous in diphtheria, so

long as they are of such a character that they do not cause destruction or inflammation of tissue; that the best applications to use are either sulphurous acid of *P. B.* strength, or carbolic acid, one part of acid to sixty parts of water; or permanganate of potass, one grain to an ounce of water; or peroxide of hydrogen (ten volumes strength); and that the best method of applying one or other of these solutions is in spray."

Dr. ALDER SMITH (of Christ's Hospital) also writes thus: "I most certainly believe in the use of topical remedies in diphtheria. I consider carbolic acid to be the best application, and would advise its use in the form of a dilute steam-spray. If the patient were old enough, I would also use to the *patches* the following solution:—R. Glycer. acid. carbol., acidi sulphurosi, liq. ferri perchlor. fort., āā, partes æquales. But I think the repeated use of a dilute carbolic acid spray to be most important.

Dr. THOMAS BARLOW coincides very much with these opinions, and suggests a mode of dealing with the disease when it attacks the nasal passages—a complication usually regarded as very serious. "There is," he says, "one group of cases of pharyngeal diphtheria where a very simple topical remedy is, I am sure, advantageous; those, namely, where there is an acrid discharge from the nostrils, and a presumption that there are shreds of tenacious mucus and half-membranous stuff on the posterior nares and the back of the palate. In these cases, so simple a measure as twice a day flushing round the posterior nares with plain water through the nostrils—the mouth being kept open—gives sometimes great comfort in breathing and swallowing, and, as I believe, lessens the risks of septicæmia. The quantity of membranous plugs which can be removed in this way, without any risk of leaving a bleeding surface, is sometimes considerable. In regard to applications to the tonsils and soft palate, glycerine of carbolic acid has seemed to me the best thing to use. It does not make a superficial white slough like hydrochloric acid and nitrate of silver; and it is not so painful, and it can be applied daily. Occasionally, it is true, membrane re-forms over the area where the carbolic has been applied; but I have seen the same thing occur with the caustics above

referred to. I suppose all are agreed that to remove membrane and leave a raw bleeding surface is not wise; and that it is only over parts where the membrane can be stripped without violence, and also around spots where the membrane is closely adherent, that one ought to apply anything. Siegle's inhaler, used with simple steam or with weak carbolic lotion, I am sure, is a comfort; and creasote inhalations (about twenty drops to the pint) I have seen, in one case at least, followed by the most satisfactory result."

Another remedy which has found considerable favour is lactic acid. Dr. PROSSER JAMES tells us that he has "considerable confidence in topical remedies, though he holds that general treatment should never be neglected. He finds local applications hasten the separation of false membrane, favourably influence the mucous surface, and may serve as antiseptics and disinfectants. To meet the first two indications, he still relies on the use of steam, as originally recommended in the first edition of his *Sore-Throat* twenty years ago, and as lately adopted by several German authorities."

"At an early stage, the frequent inhalation of hot vapour should be employed; and, if the membrane increase in quantity, the steam should be used more frequently, until it is almost constantly breathed. For this purpose, it may be necessary to place the patient in a croup-tent: but in such cases it is most necessary to see that fresh air, as well as vapour, finds free access. If the vapour be produced by the moistening of quicklime, it is thought that particles of the lime may be carried up with the steam and produce a favourable effect, for it is found that lime-water will dissolve many false membranes. As a solvent, however, Dr. Prosser James has most confidence in lactic acid, which, both in the form of spray and freely applied with the brush, he has seen rapidly followed by excellent results. The spray of lactic acid, he thinks, sometimes fails because the solution used is too weak, or is not applied often enough. In severe diphtheria, with much false membrane, it is idle to expect great effects from very weak applications. If the lactic acid is to act as a solvent, it must be used freely; and this treatment may well displace the use of mineral acids

and caustics, which were once so largely used. The steam may be made antiseptic by carbolic acid being diffused through it. Other antiseptics and disinfectants may be used conjointly with the steam; but they are usually more serviceable a little later, when the membrane has more or less separated. Then, too, those remedies which tend to restore the mucous membrane come into play, and should be diligently employed.

"When the nasal passages are involved, they should be carefully washed out with a weak antiseptic solution. A lotion of carbolic acid, or a sulphocarbolate, salicylic acid, or a salicylate, may be used with a douche or a syringe every hour, or even oftener, if the discharge be considerable. This treatment should be commenced as soon as ever the nose becomes affected, and diligently persevered in. If the lotion be weak, it can scarcely be used too often. If the passages become clogged, it will be necessary to clear them with a weak alkaline douche, and then to return to the antiseptic lotion. At a late stage, it may be desirable to employ an astringent lotion. If so, it should be weak. As an alternative lotion for the nose, Dr. Prosser James recommends a solution of bisulphate of quinine—a very soluble salt—which he has used as a local application where the addition of acid to the ordinary sulphate, to effect solution, was undesirable."

Dr. Richard Neale also says: "I find lactic acid, applied with a brush, unfailing in its speedy action, removing the false membrane, and preventing its re-formation—a result to which I attach very great importance in the treatment of such cases."

From time to time, evidence has been brought forward which tends to show that diphtheria has some connection with fungoid organisms. The pages of this journal contained, on March 5th of this year (p. 356), a short abstract of the interesting experiments of Mr. Talamon in Paris; and again, only a fortnight ago, an interesting paper by Dr. Michael Taylor of Penrith. Dr. Burney Yeo refers to this point in the etiology of the disease. He says:

"I am disposed to set much store by the local application of antiseptic or mild caustic



substances to the seat of the diphtheritic exudations, when this is practicable. The probable fungoid origin of the contagium gives a rational foundation for such treatment, while the results of actual experience alike commend it.

"If the disease is seen quite at its onset, or when only a few circumscribed patches of the characteristic exudation can be seen on the tonsils, uvula, soft palate, or their neighbourhood, a good application consists of equal parts of solutions of perchloride of iron and glycerine, which should be applied by means of a small piece of cotton-wool tied firmly to a piece of stick, the whole of which can be burnt after using it. Equal parts of carbolic acid and glycerine is also a good local application, used in precisely the same manner. These applications should be made twice or three times in the day, and in the interval the patient, if able to use a gargle, should wash out the throat and mouth frequently with a solution of permanganate of potash, or one of chlorate of potash (10 grains to the ounce), to which a few drops of hydrochloric acid have been added.

"But it often happens that we do not see these cases until the diphtheritic exudation has become too diffused to render these means effectual in arresting the process of continuous self-infection, which is one of their great objects. These agents obviously cannot be applied in this manner when the larynx and trachea are invaded. In such cases, I am in the habit of prescribing the use of a warm spray, containing half an ounce of glycerine of carbolic acid, and 80 grains of borax to 8 ounces of warm water. This should be freely and almost constantly used, by means of a large Siegle's spray-producer; and, in the case of children, this spray should be so directed as to be continuously playing over the mouth and nose of the patient, and diffused through the atmosphere which he breathes. A strong solution of tartaric acid is said to have remarkably solvent action on the diphtheritic membranes, and has been used with advantage in France; but I have no personal experience of its use."

Dr. Frederick Roberts sums up for us the objects to be held in view in the use of local remedies, and the mode by which these objects may be attained; his words form a fitting con-

clusion to this report. "Local applications are," he says, "in my opinion, of more or less value in most cases of diphtheria, but they require to be used with judgment, and with a definite idea as to the purpose or purposes for which they are employed. Taking these purposes in order, the first is to prevent the spread of diphtheritic deposit at an early period of the disease, by the direct application of some strong agent upon and around the deposit. It is doubtful how far such an object can be attained, but in some cases, perhaps, it may be. The applications which can be used for this purpose are either the solid stick, or a strong solution of nitrate of silver (3i to 3i); equal proportions of hydrochloric acid and water; or tincture or solution of sesquichloride of iron, strong, or mixed with an equal quantity of water or glycerine. The liquids must be applied efficiently once for all, by means of a suitable throatbrush. The repeated application of strong agents is to be decidedly deprecated.

"The second object is to dissolve or remove the diphtheritic material, or to alter its characters, so as to render it innocuous. The frequent inhalation of steam is probably of service in some of these ways. What agents are capable of dissolving diphtheritic membrane, is a matter to which more attention might well be directed; but it seems that lactic acid, phosphate of soda, and other agents have this power. Chlorate of potash, diluted tincture of iron, and other applications are also useful for some of these purposes.

"The third, and certainly in many cases the most important purpose, is to prevent putrefactive and gangrenous changes, or to remove or act upon the products of these changes, so as to prevent their absorption into the system, and consequent septicæmia, the infective properties of the materials being probably at the same time destroyed. Here various applications may be used, such as chlorate of potash with dilute hydrochloric acid, chlorinated soda and carbolic acid, Condry's fluid, sulphurous acid, borax, tincture of iron, etc. All these, of course, must be properly diluted. As a subsidiary object, the relief of throat-symptoms must be kept in view, and this is more or less effected by the use of some of the agents already

mentioned. The inhalation of steam, and the frequent sucking of pieces of ice, need to be specially noticed here, as they often give great relief.

"With regard to the method of application, I certainly am strongly in favour of the spray, either by means of the ball-apparatus or of Siegle's spray-inhaler. Many patients cannot gargle effectually, especially children, and the movements involved in the act are liable to be injurious. The frequent use of the throat-brush is also open to objections, and I cannot see the advantage of blowing in powders, as some have recommended. It must be remarked that, in the case of children who resist strenuously all kinds of application, it may do more harm than good to persevere with them; but this must be left to the individual judgment of the practitioner. If used at all, they ought always to be employed efficiently, and under the personal superintendence of the practitioner, with the aid of a competent nurse."

We have also received replies from several physicians, who hesitate to speak in favour of the use of local remedies, only because they regard their experience in the matter as too limited to warrant the expression of a decided opinion. Among this number is Dr. Sydney Ringer, who, however, informs us that he places great reliance on local remedies. He has seen good results follow the use of carbolic acid and glycerine to the diseased parts, and advises, in combination with this, the internal administration of a mixture containing perchloride of iron.—*British Medical Journal*.

**LEPROSY.**—At the Société Médicale des Hôpitaux, M. Cornil made a communication on the subject of the pathological anatomy of leprosy, and stated that he had found a number of bacteria in portions of hypertrophied skin, which would become a source of contagion in the ulcerative stage of this disease. M. Labbé said that he heard the statement with pleasure, as he had been treating a young leper with hypodermic injections of carbolic acid, on the hypothesis of the parasitic nature of the complaint. The improvement had been so great that he did not despair of curing him.

**RELATIONS OF SYPHILIS TO RENAL DISEASE.**—E. Wagner (*Deutsches Arch. f. Klin. Med.* xxviii. s. 94) says that out of sixty-three cases which might with great probability be attributed to syphilis, he found acute Bright's Disease, eight times; chronic parenchymatous nephritis, four times; granular kidney, seven times; atrophy of one kidney, six times with compensative hypertrophy or amyloid degeneration of the other; amyloid degeneration thirty-five times, and renal syphilis, three times.—*British Medical Journal*.

#### FUMING INHALATIONS IN ASTHMA.

There can be no question as to the value of fuming inhalations in the treatment of asthma. The ordinary nitre-paper often fails, because it is not strong enough. For some time past, I have been in the habit of using very thick and strong nitre-papers, which may be called "nitre-tablets." They contain both chlorate and nitrate of potash. Each consists of six pieces of white blotting paper, about six inches square, and they are made by dipping them into a hot saturated solution of nitre and chlorate of potash. Before the pieces are quite dry, they may be sprinkled with Friar's balsam, spirit of camphor, tincture of sumbul, or some aromatic. The nitre-paper so prepared is as thick as cardboard, each piece consisting of six pieces of blotting-paper, closely adherent, and covered all over with crystals of saltpetre and chlorate of potash. The door and windows having been closed, the tablet is placed on a fire-shovel or piece of metal of some kind, and folded down the middle, so as to make it like a tent or the cover of a book. When lighted at each end, it burns very quickly, throwing out a flame often four or five inches long, and giving rise to dense volumes of smoke. The asthmatic patient almost immediately obtains relief, and drops off into a quiet slumber, from which he awakes refreshed. These tablets often succeed when the ordinary nitre-papers do no good. They nearly always induce sleep, and I have used them with success in cases of insomnia, when most of the ordinary remedies have failed. Large pastilles composed of equal parts of nitre and lycopodium are also useful in asthma.—WILLIAM MURRELL, M.D., Lecturer on Materia Medica and Therapeutics, Westminster Hospital, in *British Medical Journal*.



## Surgery.

### EXCISION OF THE HIP-JOINT.

The committee, appointed last session by the Clinical Society to inquire into the value of excision as a means of treating disease of hip-joint in childhood, has presented its report, which was read by Mr. Howard Marsh at the last meeting of the Society. The report is signed by Messrs. Bryant, Croft, Holmes, Hulke, MacCormac, Marsh, and Lyell. As was suggested by the President, it deals especially with the following points. 1. The indications for resorting to the operation; 2. The results obtained from the operation as to (a) mortality, (b) the after condition of the limb; 3. The method of operating, as to (a) the amount of bone removal, (b) the use of antiseptics; 4. The nature of the disease, whether scrofulous or not. The report is founded on the two papers on Excision of the Hip-joint read by Mr. Croft before the Society, and published in the thirteenth volume of the *Transactions*, the second paper containing the history of 45 cases; on an analysis of all the cases—401 in number—admitted into the Hospital for Hip-disease in Childhood down to the end of 1879, 384 of these cases being treated by prolonged rest and weight-extension, without operative interference, and 17 being treated by excision or amputation, after removal elsewhere; on the examination of 37 specimens derived from Mr. Croft's cases, and of 19 collected from other sources; and on the results of excision, where traceable, in 158 cases from the Evelina, Guy's, the Middlesex, and the University College hospitals.

The information thus obtained is summarized under various headings: 1. The proportion of recoveries to cases that ended fatally (a) after excision, (b) where rest and weight-extension only were employed; 2. The causes of death; 3. The period occupied by treatment; 4. The subsequent condition of the limb. The 45 cases in Mr. Croft's tables include 19 cases, or 42 per cent. of recoveries; 18 cases, or 40 per cent., of deaths; 8 cases, or 18 per cent., still incomplete. The mortality of 40 per cent. on the total of 45 cases is thus made up: 15.6 resulting from the operation, 13.4 from some

form of tubercular disease, 6.6 from albuminoid disease, 4.4 from causes unconnected with the joint-disease; so that, if the deaths unconnected with the disease are excluded, the mortality amounts to 35.6 per cent. The average period of treatment in cases of recovery was one year and three-quarters, while the average total duration in 14 cases was three years. In thirteen of these cases, the average shortening of the limb was two inches and three-quarters; while the proportion of cases in which the movement was free, limited, or *nil*, was as 11, 6, and 3. (b) Of 260 cases of suppuration treated at the Hospital for Hip-disease by rest and extension only, 42.3 per cent. were cured or convalescent on discharge, 33.5 per cent. died, 24.2 per cent. were incomplete cases. The mortality of 33.5 per cent. is made up of 20.4 resulting from the disease, 9.2 from some form of tubercular disease, 3.9 from causes unconnected with the disease. If the deaths from causes unconnected with the disease be excluded, the mortality amounts to 30.4 per cent. The average period of treatment was found to be two years and a half in cases of recovery, and one year and a half in cases that died. The average total duration of the disease in cases of recovery amounted to rather more than four years. In 32 cases, the average shortening of the limb was, in 24 good cures, one inch and a quarter; while in two cases there was no shortening. The cases in which the movement was free, limited, or *nil*, were proportioned to one another as 5, 4½, and 3. Of 35 cases, 30 walked with slight or no limp, 5 with considerable limp.

The remaining cases in the table (124 in number) were instances of non-suppurating, and are composed of cures or convalescents, 69.3 per cent., as compared with 42.3 of suppurating cases; incomplete cases, 20.2 per cent., as compared with 24.2 of suppurating cases; deaths, 10.5 per cent., as compared with 33.5 of suppurating cases.

The deaths from tubercular disease amount to 7 per cent. in a total mortality of 10.5 per cent. The average total duration in cases of recovery was rather less than three years. While the proportion of cases in which the

movement was free, limited, or *nil*, was as 5.3 and 3. In a total of 17 cases, the average shortening in 12 good cures was one inch; in 3 moderate cures, three inches and a quarter; in one there was no shortening; and in one there was three quarters of an inch of apparent lengthening. Of 22 cases, 19 walked well; 3 had a considerable limp.

In 56 specimens examined by the committee, more or less necrosis had occurred in 33—*i. e.*, in 59 per cent. In some of these, firm sequestra of considerable size were present; while, in others, the sequestra consisted merely of small fragments of softened cancellous bone. Of a total of 203 cases of excision, 29, or 13.7 per cent., proved fatal directly from the operation.

The conclusions arrived at by the committee as to the indications for resorting to the operation of excision are: that it should be adopted in cases—1. Of (1) necrosis of the entire head of the femur, and its conversion into a loose sequestrum; (2) the presence of firm sequestra either in the head or neck of the femur, or in the acetabulum; (3) extensive caries either of the femur or the pelvis, leading to prolonged suppuration and the formation of sinuses; (4) intrapelvic abscess following disease of the acetabulum; (5) extensive and old standing synovial disease and ulceration of the articular cartilages, with persistent suppuration; (6) displacement of the head of the femur on the dorsum ilii, with chronic sinuses and deformity. It is pointed out that one of these conditions is probably present when suppuration occurs early in the course of hip-joint disease, and is accompanied by severe local and constitutional symptoms. In such cases, loose sequestra may sometimes be found and removed without sacrificing the articulation. II. Excision should also be performed when, in cases of suppuration, enlargement of the liver, or albuminuria, indicating the presence of degeneration of the viscera, is detected. III. When suppuration continues free, fresh sinuses are formed, or extensive burrowing is in progress, and the patient is losing ground in spite of careful treatment by rest and free drainage. IV. In disease of the pelvis, to provide an efficient drainage for suppuration, which may

be sometimes detected near the floor of the acetabulum by the finger passed into the bowel; though pelvic disease renders the prospect of recovery, under whatever treatment is adopted, more than usually doubtful. The committee consider that complete rest and extension, and the withdrawal of matter, should always be first patiently tried, and operative interference only resorted to when these other means have failed to secure the favourable progress of the case.

The results obtained by excision show a mortality of 40 per cent., as compared with a mortality of 33.5 in cases of suppuration treated by rest and extension; or, excluding deaths from accidental causes unconnected with the disease, 37.7, as against 31.6. This slight difference does not certainly tell for much in favor of the opinion either of those who countenance or oppose operative interference, as at present conducted.

On comparing the condition of the limb in cases treated by excision with that resulting from treatment by rest and extension, the committee is of opinion that movement is more frequently present, and also more extensive in the former class; but that patients often walk insecurely, and with considerable limp; whilst the limb, after treatment by rest and extension, though frequently more or less fixed, is firmer, and more useful for the purposes of progression. Only as much bone should be removed as is actually diseased; and the femur should not be divided below the great trochanter; nor, except in the rare cases in which it is extensively involved in the disease, should the great trochanter be removed, and the attachments of the glutei muscles thereto should be preserved. These muscles, if cut, should be divided in a direction parallel with their fibres, and then retracted, as recommended by Mr. Croft. But if the pelvis be diseased, the trochanter may be removed, since, if left, it is apt to be drawn up into the acetabulum, interfering with the free escape of pus through the cavity of the joint. The committee had no evidence before it upon which to form any definite opinion as to the use of antiseptic dressings in the operation of excision of the joint; nor does the committee offer any decided opinion as to the connection



of hip-disease in children with scrofula, as the questions relating to scrofula and tubercle are still *sub judice*. But, of 429 cases of hip-disease coming under the notice of the committee, 39, or 9 per cent., died of some form of tuberculous disease.

Lastly, in nearly 60 per cent. of the pathological specimens examined by the committee more or less necrosis had occurred, in some of which the dead bone formed firm large sequestra, whilst in others it consisted of small fragments of softened cancellous bone, which might probably have been disintegrated and thrown off unobserved in the discharge. That this had occurred in several of the cases examined, seemed to be proved by the severity of the suppuration that had taken place, as evidenced by the large number of cicatrices that remained.

This report, upon which the committee has spent much time and trouble, contrasting two sets of similar cases, one treated by rest and the other by excision, and for which the committee has otherwise very carefully investigated the evidence before it, certainly does not seem to bear out the view entertained in some quarters that the operation of excision is calculated to secure results materially superior to those obtained by the well-tried methods of rest and extension by weights and other means. We may regret that no royal road to recovery is opened to us by a more frequent resort to operation; but for the present, at any rate, it would appear that we must still be content to depend, in the majority of cases, for our treatment, on the expectant method.—*Brit. Med. Jnl.*

THE TRANSPLANTATION OF BONE. — The greatest discovery in surgery, thus far in the year 1881, is that of Dr. William MacEwen. He has successfully transplanted bone—fragments of wedges of bone taken from patients for curved tibiae—into the arm of a child whose limb was useless by reason of extensive necrosis: two-thirds of the humerus had been destroyed and no repair of bone had taken place.

A good new humerus was the result, less than an inch shorter than its fellow.—*Canada Med. and Surg. Jour.*

## QUIET VERTEBRAL CARIES.

BY EDMUND OWEN, F.R.C.S.

A sickly-looking boy, aged 10½ years, with old rachitic curvatures of the legs, was brought to the out-patient department, Hospital for Sick Children, Great Ormond St., on May 7th, by his mother, who said that he was suffering from "lumbago," though the pains were not sufficient to affect his appetite, or to disturb his sleep. Although he was still attending school, and running about much as usual, he was, the mother thought, losing flesh. On asking her how he came downstairs, she said that he now came down very slowly; that he would place each foot on every stair, and that he would always ease himself down by the balusters.

On stripping him, and placing him on his back on the couch, the crease of the right groin was found almost obliterated, and deep-seated fluctuation was detected in the iliac fossa, and in the upper part of Scarpa's triangle. By alternate pressure over these two regions, it became evident that the fluid (purulent) collections communicated beneath Poupert's ligament. The mother had noticed the fulness, for the first time, a fortnight previously.

The movements of the hip-joint were free. On turning the boy over, and examining the back, there was no tenderness discoverable along the spine; nor was there any abnormal projection to be detected. On telling him to stand down on the floor, he slid gently and cautiously off the couch, as if afraid of jarring himself; but as he walked naked once or twice across the room he stepped out boldly and held himself erect—unnaturally erect. On being asked to pick up a pin from the floor, he lowered himself at the knees, and a little at the hips, but kept his loins as stiff as a board. It was evident that the stiffness and the lumbago were due to disease of the bodies of the lumbar vertebrae, and consequent irritation of the roots of the neighbouring spinal nerves. The treatment was to consist in absolute and prolonged rest in bed.

REMARKS.—This is the kind of case which is very apt to be overlooked by either of those gentlemen for whom so many text-books are now being compiled—the busy practitioner and the student; the former from want of the time necessary for

an exact examination, the latter from want of knowledge and method. For the thorough inspection of a child, it should be stripped stark naked, so that every movement, and the behaviour of every joint may be viewed at the same moment. In the young and supple patient, when one joint is by disease or injury thrown out of working order, the deficiency is so cleverly made up by neighbourly and relative articulations, that the real pathological condition may possibly be unappreciated, or entirely escape detection. Thus, for example, the joints of the knee, and the spine, and the pelvis may supply the deficiencies of the inflamed or ankylosed hip. And, in its turn, the hip, with the knee, apologises for the affected spine; and when the function of the shoulder-joint is temporarily or permanently impaired by inflammation or adhesions, the scapula plays so freely over the back and side of the chest that, unless the parts are quite uncovered, so that the movements of the two shoulder-blades may be watched and compared from the front and the back, there may be a failure of diagnosis. More than this, a physical examination carried out as suggested by these remarks, may be performed with equal satisfaction to the child and to the surgeon, for the latter may have been enabled to make up his mind as to the nature of the affection without touching his little patient; and as some irritated and apprehensive children cry as soon as they are touched, and assure one that the least handling of the soundest part causes pain, this preparatory inspection, even if it have not been all-sufficient, will probably have been the means of establishing a good understanding between those most concerned in the interview.

But to return to the subject of these clinical remarks. Caries in the lumber region of the spine may advance much further, without recognition, than it could have done in the districts of the neck or chest. In the last-named region, a slight falling together of the bodies of the vertebrae would be accompanied by so obvious a projection of the spinous processes which are already prominent, that the mother herself notices the back "growing out," and applies for help; and, in the cervical region, the stiffness, the distressing pains in the head, neck, or chest, the chin propped upon the table, or supported

by the hands, will be sure to obtain early attention. But when the lumbar vertebrae are diseased, and the child is suffering from that constant irritation of the lumbar nerves which he designates as "belly-ache," the mother believes herself to be quite competent to deal with the case; and if the pains be in the back, or along the thighs, so that the mother may call them rheumatism, lumbago, or sciatica, she is still equal to the occasion, for as yet there may be no apparent projection of spinous processes, although probably that part of the column is rigid and straight. After a further time the projection of a process may be detected, increasing between the masses of the erector spinæ.

When pains about the trunk or limbs are persistent, though of obscure origin, the question may well be asked, whilst the child is being undressed, "How does he come down stairs?" If the answer be, "Much as usual," or one hears that he sometimes comes securely down the middle of the course or by the wall, and that he jumps down from the bottom stair, the child is in little likelihood the subject of spinal disease; but if we are told that he asks to be carried down, or refuses to be led down, preferring the leisurely and cautious descent which he may make by himself with the aid of the balusters, and if, at the same time, he complain of pain in bilaterally symmetrical areas, by the linea alba, the groins, or the thighs, examination will probably reveal the existence of central (spinal) disease.—*British Med. Journal.*

#### THE ATTENDING SURGEONS AND THEIR CRITICS.

The *Louisville Medical News*, in a recent article, entitled "The President's Surgeons and their Critics," expresses the general sense of the community and of professional men, who are imbued with an elevated tone in their relations to the public and to their fellow medical men. It says:—

The President's medical attendants labour under peculiarly embarrassing circumstances in this, that they are compelled to treat their case, so to speak, under the eye of the whole world. The high official position of the patient, the fiendish attempt upon his life, and the great issues depending upon his recovery or death, have carried the witnesses far beyond that



state of sober conservatism which should characterize all comments upon the management of such a case; and the surgeons in attendance have been submitted to much unfavorable criticism by the secular press, while in too many instances the medical press has put in a word of censure.

It should not be forgotten that several eminent surgeons are employed in the case. And the unprofessional critics should remember that while these gentlemen do not know everything, they probably do not stand in need of advice from those who know nothing of medicine or surgery; and the professional critics might, on reflection, see that it is neither graceful nor ethical to condemn at a distance and upon theoretical grounds the movements of professional brethren (most of them of acknowledged ability) who are upon the ground, and noting the symptoms from day to day, are doing all that their judgment warrants in the case.—*College and Clinical Record*.

#### MR. LISTER'S DRESSINGS.

As he announced recently to the Clinical Society, Mr. Lister has lately been making extensive use of eucalyptol in place of carbolic acid. Eucalyptus oil itself, which is the active ingredient in all these new preparations, is a colourless, limpid, watery fluid, the essential oil of the *Eucalyptus globulus*. This is used undiluted, as a dressing in the same class of cases as carbolic oil is commonly used. It is also made into an ointment, of which the following is the formula: Vaseline,  $2\frac{2}{3}$  parts; paraffin wax,  $1\frac{1}{2}$  parts; eucalyptus oil, 1 part. The formula for the eucalyptus and iodoform emulsion referred to in the report of one of Mr. Lister's cases of ununited fracture of the patella, is as follows: Eucalyptus oil and powdered gum acacia, of each, 96 grains; iodoform, 8 grains; water, to 2 fluid ounces. In operations about the genital organs, or other parts where the presence of numerous hairs and their follicles makes it difficult to render the skin thoroughly antiseptic by the ordinary methods, Mr. Lister has latterly, after shaving and cleansing the parts, applied to them a "salicylic cream," which is thus prepared. Six parts of carbolic acid and glycerine (1 in 20)

are rubbed up in a mortar with one part, or one part and a half, of salicylic acid, until the mixture is of the consistency of a thick smooth cream. The mode of preparation of the eucalyptus gauze, Mr. Lister intends, we believe, to make public before long; meanwhile we may say that it may be obtained from Milne, of Eagle House, Ladywell, Kent. As eucalyptol is very volatile, it is well to place in the tin box in which the gauze is kept, an open phial of eucalyptus oil, to prevent the deterioration of the dressing.—*British Medical Journal*.

#### INTRA-PERITONEAL TRANSFUSION.

The grave results which often follow the escape of blood into the peritoneal cavity would scarcely lead to the anticipation that it would be found a suitable site for the transfusion of blood. Nevertheless, it has been shown to be such by Ponfick, and several cases in which intra-peritoneal transfusion has been employed have been recently published by Kaczorowski. The injection of the blood is by a trocar introduced through the linea alba, the blood being poured through a glass funnel furnished with a flexible looped tube. The operation is performed under strict antiseptic precautions, and the admission of a little pure air into the peritoneal cavity appears to be harmless. The method is recommended especially in prolonged febrile diseases, in which the heart's action fails, and also in chronic anæmic diseases. The reaction of the serous membrane is said to be slight, and often *nil*. Of the cases recorded, one was a female, twenty-one years of age, suffering from puerperal septicæmia; two transfusions were made, each of 500 grammes of defibrinated blood; the patient was suffering from anæmia, hysteria, and spinal irritation, and recovered after a single transfusion. The third case was one of phthisis, and the patient was improved by the operation, but died three months later. The fourth was that of a woman fifty years of age, very anæmic and depressed, with fungous ulcers in the neck; after the latter had healed there was no improvement in the general condition, but convalescence rapidly set in after the transfusion of 600 grammes of blood. The last patient was a drunkard, forty-years of age, suffering from a severe attack of exanthematic typhus, with bed-sores. After the transfusion of 400 grammes of blood the fever lessened, the other symptoms improved, and the patient recovered.—*London Lancet*.

## Midwifery.

### PREGNANCY VOMITING.

BY HENRY GIBBONS, JR., M. D.,

Dr. J. Marion Sims contributes a paper on pregnancy vomiting to the *Archives of Medicine* (June, 1880), in which after referring to the causes as suggested by Graily Hewitt—flexure and malposition of the uterus; by Dr. M. O. Jones, of Chicago—granular erosion of the cervix; and by Dr. Copeman, of England—induration and contraction of cervix; he states that he also has resorted with success to the treatment proposed by these writers, viz.: Support for the flexed uterus, and nitrate of silver applications for the erosion and dilatation of the cervix when contracted. Copeman's method consists in gradually forcing the finger into the os and carrying it along till the first joint of the finger enters the cervical canal, taking care not to push it so far as to impinge against the os internum. Dr. Sims reports a case, the only one on record, in which the latter plan being fully adopted, a miscarriage resulted, showing that it was not devoid of danger. He attributes this result partly to the pushing of the fundus backward by the hand on the abdomen, to prevent excession, while the finger of the other hand was forced into the cervix, and partly to a tendency to miscarry.

In discussing this subject of morning sickness before the Berlin Medical Society, Dr. L. Rosenthal recognises three varieties: (1) the ordinary sickness; (2) the sickness following every meal, and lasting even after quickening, but not destroying appetite; (3) the rare form often accompanied with diarrhoea and salivation and failure of nutrition, and sometimes followed by death. Of the third variety, Paul Dubois saw 20 fatal cases, and of 118 cases given by Guèniot, 46 proved fatal. "The condition is doubtless dependent upon some abnormality of the uterus, and generally of the cervix; but since such abnormalities are so very common, why is this effect so rare? Because a neurotic tendency must be present also as a predisposing cause. There are many analogies between hyperemesis gravidarum and

nervous or hysterical vomiting." Dr. Rosenthal states that ice, ipecac, calumba, and oxalate of cerium have enjoyed the most repute in the treatment. He has resorted to Copeman's procedure in two instances with success, and recommends it even in moderate cases; while Dr. Sims holds that it should be reserved for those which are urgent and rebellious.

The application of a ten per cent solution of nitrate of silver to the cervix every two or three days is strongly advocated by Dr. Welponer (*Wien. Med. Woch.*, May 22, 1880), who has thus cured three obstinate cases that resisted all other means. Dr. J. W. Hickman (*Med. & Surg. Reporter*, December 13, 1879), urges larger doses of the oxalate of cerium—ten grains as often as necessary, taking care to give the first dose half an hour before the patient rises from bed. He believes that arsenic is indicated when the vomiting is followed by painful retching, and that ingluvin stands first among the agents reviewed.

Dr. J. S. Forwood (*Med. & Surg. Reporter*, July 10th, 1880), during twelve years' practice has treated two hundred or more cases of morning sickness with an infusion of calumba, ginger and senna, and asserts that this combination is as much a specific in pregnancy vomiting as quinine is in intermittent fever. His formula is:—

R Rad. Calumbæ Contus : Rad. Zingiberis ..... aa ʒss.  
Fol. Sennæ ..... ʒi.  
Aq. Bullient..... oj.  
M. Ft. Infus.

Sig. Wineglassful before each meal.

Dr. Pinard (*Annales de Gynecologie*, May, 1880), has used in an obstinate case the inhalation of oxygen. After seven weeks of vomiting, ten litres of oxygen were inhaled in one day, twelve on the second day, and fifteen on the third, when the patient was cured. D. Hertzberg (Berlin), uses three granis of chloral in solution every two hours until vomiting stops; and, finally, Dr. W. W. Potter (*Am. Jour. Obstet.*, Jan., 1880), advocates absolute rest for the stomach, no food or drink being allowed by mouth; all aliments and medicines to be given per rectum.

No mention is made in any of the references to the use of strychnia, which I have found of



signal service in a large proportion of cases; while in others it has failed completely. Nor of the viburnum prunifolium, which in many cases has proven an efficient uterine sedative. In a recent case of distressing pregnancy vomiting under my care, immediate, though temporary, relief followed upon placing the patient in Sims' position, and distending the vulva. The uterus was thus permitted to rise from the hollow of the sacrum into which it was pressed. The symptoms returning in a modified degree were treated with the viburnum, which appeared to exert a decidedly favorable influence.

The variety of methods above mentioned clearly indicates the wisdom of studying the causation of morning sickness in any given case before attempting its treatment. If it be due to a fallen or flexed uterus, we cannot expect general treatment to have any immediate effect; and if there be simply a hysteroneurosis, local medication may aggravate rather than benefit.—*Pacific Medical and Surgical Journal*.

#### POSITION IN LABOR.

BY HENRY GIBBONS, JR., M. D.

An exhaustive paper on "The instinctive (or natural) and physiological position of women in labor," was read by Dr. Geo. J. Engelmann, at the late session of the American Gynecological Association. To one accustomed to look upon the dorsal or lateral positions as the only ones the woman should assume while in labor or at birth, the tabular statement presented showing the many positions that are adopted by the different races of the world must appear strange indeed. The recumbent position, in bed, is by no means general, and the side position is almost peculiar to England. The semi-recumbent position is assumed in Italy, Germany, Syria, and Japan, by the native races and tribes in various parts of the United States, in Mexico, Chili, etc. The sitting position upon a chair, rocking chair or stool, on the lap of the husband or other person, or in a hammock, is adopted in parts of England, Scotland, Wales, Germany, Russia, Italy, Greece, China, Palestine, Syria, India, Turkey, Arabia, in several countries of Africa, by Negroes in portions of the United States, and by some of

the Indian tribes; in Venezuela, Australia, and Sandwich Islands. In many localities, in Italy, Germany, Russia, Scotland, Japan, and North Australia, and among some Indians and Negroes of the United States, the patient is suspended, or partly suspended, or hangs upon the neck of an attendant. The kneeling position is quite common, and is found to be practised in Spain, Italy, Russia, Greece, Scotland, England, Wales, Kamschatka, Mongolia, Persia, Ethiopia, Abyssinia, Indian Territory, and various parts of the United States, Mexico, Nicaragua, and New Zealand. The squatting attitude is taken in Russia, Arabia, Persia, Indian Territory, Mexico, Guatemala, Polynesia, and West Micronesia; and patients even stand while delivered in France, Germany, India, Ethiopia, East Africa, Indian Territory, Mexico, and Philippine Islands. Finally, the knee-chest and knee-elbow positions are taken by some Indian tribes of the United States. The author concludes that the instinct of the patient generally inclines her to assume the semi-recumbent position, and that this is the one which should generally be adopted. As between this and the English lateral position, there has never appeared to me any doubt of the superiority of the former.

Matthews Duncan has shown that gravity alone is sufficient to effect delivery in some cases, and that in no position of the body—either dorsal, semi-recumbent, sitting, standing, kneeling, squatting, etc.—save upon the side, is the axis of the parturient canal horizontal. The semi-recumbent position places the axis of the brim of the pelvis more nearly perpendicular, and hence in this position the greatest assistance is gained from gravitation. At the same time it must be remembered that Schroeder has demonstrated that in semi-recumbency the larger portion of ruptures of perineum take place.—*Pacific Medical and Surgical Journal*.

The Fifth International Pharmaceutical Congress met in London, Eng., on the 1st of Aug., under the presidency of Mr. Greenish. The Congress strongly supported its predecessors in the advocacy of a Universal Pharmacopœia. The next meeting is to be held in Brussels three years hence.

## Correspondence.

### THE MEDICAL COUNCIL AND THE LAW.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

SIR,—In the July number of your JOURNAL appeared an editorial headed, "The Case of Dr. John B. Hall." After giving the resolution moved by Dr. Bray, and supported by a majority of the Medical Council, as follows: "That Dr. Hall be examined by the Homœopathic members of the Council, as an inexpensive method of testing his attainments, as this is a special case, and if found qualified, that his name be put on the register," you give your reasons for disapproving of the conduct of the Council.

In the August number of the JOURNAL a correspondent demurs to this "inexpensive method" of licensing homœopaths.

It seems to me that the main—the legal points—attending this case, have not attracted either your attention or that of your correspondent. Really, I cannot understand how it comes that educated gentlemen, as the members of the Medical Council may be assumed to be, having the Ontario Medical Act—not by any means a very complex law—before them, can allow the plain provisions of that Act to be violated, in the many instances it has been, by the Council. By the 28th section of the Act it is enacted that the Council shall elect a Board of Examiners, "whose duty it shall be, at least once in each year, to examine ALL candidates for registration, in accordance with the By-laws, Rules, and Regulations of the Council."

It will thus be seen that the Council, having elected the Board of Examiners, must leave the examination of ALL candidates with them, and have no power to take the matter out of their hands and transfer it to homœopathic members of the Council, or any other parties. If this opinion be correct, the license to practise, obtained in an illegal manner by Dr. J. B. Hall, can be set aside on application to the Equity Division of our Courts by any interested party.

Again, the Council decided last year the fee to be paid by each candidate presenting him-

self for examination. Did Dr. Hall pay that fee previous to his so-called examination? If not, how can he have legally acquired the right of registration?

The latter part of Section 29 says: "Such examinations to be held in Toronto or Kingston, at such times and in such manner as the Council may, by by-law, direct." Taken in conjunction with the following, in Section 31: "The Council may . . . prescribe the subject and modes of the examinations, the time and place of holding the same, and generally," &c., it would appear that there is no authority for holding the same examination in both Toronto and Kingston, at or about the same time, year after year.

Should the views above expressed prove correct, the *private* examinations granted by the Council, the "inexpensive" or homœopathic examinations, and the unpaid-for, do not confer a legal right to registration. If they are erroneous, will those, who understand the law better than the writer, be good enough to set him right.

A. A. R.

Toronto, 25th August, 1881.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

SIR,—In seeking an answer to your conundrum, "Why did only four members of the Ontario Medical Council vote against Dr. Bray's inexpensive method of licensing a Homœopath?" &c., it is but fair to remember, that a motion proposed by a prominent official is likely to carry more weight than if it came from a humbler source. Hence, probably, some of the weaker brethren were satisfied to follow their leader. For them it is an unpleasant record. The conundrum is—Will he, if President next year, see that all Homœopaths be licensed by the "inexpensive method?"

Yours, &c.,

INTERESTED 4TH YEAR.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

SIR,—In the Toronto *Daily Globe* of the 5th ult., I notice that it has been decided in the Ontario College of Pharmacy, to amalgamate the offices of Treasurer and Registrar.



Would it not be in good taste, considering the amount of feeling there has been expressed in time past by the general profession, for the Ontario Medical Council to adopt the same system of amalgamation at its next meeting?

If for no other reason, that of economy ought to make such a course desirable.

Yours,

M. D.

It will be remembered that when Dr. Aikins was elected Treasurer, it was with the view of securing a stable and reliable man, who could give large security for the moneys entrusted to his care. The duties of the office have been so satisfactorily performed that the Council has wisely seen fit to make no change to pacify the *ad captandum* and hysterical querulousness of a clique. The economical argument falls to the ground, when we reflect that it would be out of the question to expect the present Registrar to discharge the duties and assume the responsibility of the Treasurership for a less (nay, rather a much greater) remuneration than has been annually accorded to Dr. Aikins. It is now a well known fact that Dr. Aikins does not come into personal contact with the Registering Students.—Ed.

#### ANSWER TO "G. W.," MEDICAL STUDENT.—

To make cow's milk more digestible add one half teaspoonful dilute muriatic acid to one pint of water. Then add one quart of raw cold milk, mix thoroughly and boil ten or fifteen minutes. *Jacobi, American Journal Obstetrics, July, 1879.*

Also, see article on Prophylaxis of Hemiplegia, by W. Thompson, M.D., in January number of CANADIAN JOURNAL MEDICAL SCIENCE, 1879.

#### ANSWER TO L. W. B., (Hinton, W. Va.—

As most druggists know, or ought to know, Fowler's Solution is incompatible with the ordinary Tincture of Iron, and the two should not be prescribed in the same mixture.—*Druggists' Circular, page 181.*

(Pharmaceutically or medically, if mixed with glycerine, they are not incompatible.—Ed.)

## THE CANADIAN Journal of Medical Science,

A Monthly Journal of Medical Science, Criticism,  
and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, SEPTEMBER, 1881.

### INTERNATIONAL MEDICAL CONGRESS.

At the meeting of the International Medical Congress, held at St. James' great Hall, Regent Street, on August the 3rd, some 3,000 medical men from all parts of the world were present.

The Congress has met altogether six times—at Paris, in 1867; at Florence, in 1869; at Vienna, in 1873; at Brussels, in 1875; at Geneva, in 1877; and at Amsterdam, in 1879.

On these occasions the number of members has ranged from 400 to 700, so that this Congress was by far the most important of the series. The foreign members numbered 1,000. Of these Germany and France each contributed 300, other European countries and America, each, 200. Of the English members, 1,000 were from London, and 500 from the provinces. Amongst the distinguished foreigners who attended the Congress were the following:—Dr. Fordyce Barker, of New York; Dr. Billings, of Washington; Dr. Bigelow, of Boston. Profs. Brown-Sequard, Paris; Busch, Bonn; Charcot, Paris; Chauveau, Lyons; Cornil, Paris; Donders, Utrecht; Esmarch, Kiel; Dr. Austin Flint, New York; Profs. Foville, Paris; Frerichs, Berlin; Goltz, Strasbourg; Gerhardt, Wurzburg; Jules Guerin, Paris; Holm-Gren, Upsala; Hannover, Copenhagen; His, Leipsic; Hardy, Paris; Horner, Zurich; Kolliker, Wurzburg; Klebs, Prague; Von Langenbeck, Berlin; Le Fort, Paris; Loven, Stockholm; Dr. Henri Guenean de Mussy, Paris; Profs. Van Overbeck de Meyer, Utrecht; Ollivier, Lyons Panum, Copenhagen, and many more; together

with delegates from the Governments of France, Germany, Belgium, Italy, the Netherlands, Austria, Hungary, Roumania, Russia, Spain, Sweden and Norway, Switzerland, the United States, Brazil, and the Argentine Republic. The business of the Congress ranged over the whole field of Medicine and Surgery. The work was divided into fifteen sections, viz.,

Anatomy—President, Prof. Flower, LL.D., F.R.S.  
 Physiology—President, Dr. Michael Foster, F.R.S.  
 Pathology and Morbid Anatomy—President, Dr. Samuel Wilkes, F.R.S.  
 Medicine—President, Sir William Gull, Bart., M.D., D.C.L., &c.  
 Diseases of the Throat—President, Dr. George Johnson, F.R.S.  
 Surgery—President, John Erie Erichsen, F.R.C.S., F.R.S.  
 Obstetrics—President, Dr. A. H. McClintock, LL.D.  
 Diseases of Children—President, Dr. West.  
 Mental Diseases—President, Dr. Lockhart Robertson.  
 Ophthalmology—President, W. Bowman, LL.D., F.R.S.  
 Diseases of the Ear—President, W. B. Dalby, F.R.C.S.  
 Diseases of the Skin—President, Erasmus Wilson, F.R.S.  
 Diseases of the Teeth—President, Edwin Saunders.  
 State Medicine—President, John Simon, C.B., D.C.L., &c.  
 Military Surgery and Medicine—President, Surg. Gen. Prof. T. Longmore, C.B.  
 Materia Medica and Pharmacy—President, Prof. T. R. Fraser, M.D., F.R.S., &c.

A most elaborate programme was issued to all members for the eight days, during which the Congress lasted, embracing not only sectional work but visits to the London Hospitals, museums, &c., excursions, garden parties, conversazioni, and general addresses by Sir James Paget, President of the Congress, and others.

Women holding medical qualifications were not admitted on a professional footing, and although a memorial, signed by forty-three women holding medical degrees, was sent to the executive, asking that their decision in this particular should be reconsidered, it was of no avail.

After the first general meeting, at which Sir Wm. Jenner, Sir James Paget, His Royal Highness the Prince of Wales, Professor Donders, and a number of others, delivered long addresses, the members of the Congress were chiefly occupied in the meetings held in the

rooms in the different parts of Burlington House and the London University. The Sections all sat at the same time, and printed notices were issued for the special direction of strangers. That every one might the more easily enter into the discussions, an abstract of all the communications to be made in the various sections was issued to each registered member. Each of these papers is published in three languages, English, French, and German. The reader of the paper spoke in his mother tongue, and the discussions had to be carried on in the same language. Besides this book of general abstract, smaller books of abstracts of papers in each section were distributed in the room of that section, so that one might with ease go into any room and at once find out all the information possible by looking over one of the sectional books of abstracts. That the subjects discussed should be all put in print, and the ideas of every separate speaker be known hereafter, a printed form was given to each member on entering any room, on which was the following in all languages: "To ensure accuracy, and facilitate the publication of the proceedings, speakers are requested before the conclusion of each meeting to hand to the secretaries of the section in writing, the substance of their speeches." This was printed on the head of a sheet of foolscap. A temporary museum was arranged at the Geological Society's rooms, Burlington House, for the use of members of the Congress. The specimens exhibited were from the private collections of a number of the leading English physicians and surgeons. It comprised 788 sections, and contained most rare and unique specimens. There was also a museum of instruments supplied by private contributors, and a section devoted to the illustrations of diseases in the living subject. The arrangement of this last most novel exhibition was very perfect. The subject, with the day and hour at which it might be seen was published, as also the name of the gentleman who was to be present to give a sort of clinical memorandum of the case, and take part in any discussion thereon which might arise.

Microscopical demonstrations were held in a room adjoining the museum on Thursday and



Friday afternoons, when a very large number of subjects were discussed, and specimens exhibited, not only demonstrating many rare forms of disease, but showing the effect of the various modes of preparing such tissues.

Before the Congress opened, and during its sitting, a most interesting exhibition took place at South Kensington. This consisted of a display of modern instruments by all the best makers, as well as of sanitary arrangements, and many other new inventions. The display of instruments was very fine, and the different hospitals had very kindly provided specimens of their peculiar methods of treating fractures, &c. A number of long halls being filled with beds to represent the ward of a hospital. Each ward was arranged exactly after the pattern of a certain hospital which it represented. The beds were occupied by dummy figures which were supposed to be suffering from the affection set forth on the bed ticket which hung at the head of the bed, splints, &c., being applied, as was most approved in that particular hospital.

A curious feature in these ward exhibits was the presence every here and there of a wax dummy figure, representing a nurse dressed in the distinctive dress pertaining to the hospital to which she belonged. These were so admirably executed that Madame Tussaud could not have put them up in better form. So much was this the case that they were being continually mistaken for nurses, and spoken to. Of the larger apparatus, such as ambulance waggons, &c., which from their size could not be admitted, very neat and perfect models were supplied. Amongst the instruments most worthy of notice may be mentioned a general endoscope, a a coil for applying heat or cold to any part, and a pocket sphygmograph. The difficulty of illuminating the inner surface of the bladder, uterus, &c., has hitherto chiefly arisen from the fact that heat has been communicated with the light introduced—whereas by this instrument the light, being produced by electricity, can be made sufficiently strong, with ease, to get a perfect view of the whole interior of the bladder or uterus, or in fact any other part of the body into which it is possible to pass a probe. The chief difficulty about this instrument is its cost, as it is accompanied by so many at-

tachments that the value becomes very great. The coil for applying heat or cold is constructed of narrow leaden tubes bent in coils to fit any part of the body. One of these may be applied and India rubber tubes attached for entrance and exit of the fluid. The makers claim for this that it is much more easily applied, and the effect is much more lasting, than is gained by the use of the old rubber coils.

The pocket sphygmograph is of particular value, as with it the difficulty of application is to a great extent overcome. It can be applied immediately, and need only be held on the wrist by the patient himself. It is in a very small case and can be easily carried in the pocket, the whole box not being much larger than the usual hypodermic case. The tracings when taken are immediately made permanent by washing their surface with a solution provided with every instrument. This little instrument has met with such general favour, that it is almost impossible to obtain one, the orders being sent in in such numbers. One will, however, be exhibited at an early meeting of the Toronto Medical Society.

As to the practical value of the congress, it is a little difficult to advance an opinion. That its ultimate result will be of the greatest possible value to the profession all over the world, no one can doubt; but from its great magnitude, one is almost inclined to feel sorry that so much of interest had to be of necessity overlooked. The publication, however, of the papers, all the points of discussion being fully brought out in them, will to a great extent overcome this loss.

The Profession at large must all feel the debt they owe to Mr. MacCormac, and others, who so generously gave up their time and attention to produce the largest and most successful meeting of the International Medical Congress, that the world has ever known. [We are indebted for the above interesting account to Dr. Arthur Jukes Johnson, of Yorkville, who has just returned from attending the Congress. We are glad to inform our readers that Dudgeon's Sphygmograph, above described, may be obtained very cheaply from Messrs. Stevens & Son, 276 Yonge St., in this city. Leiter's improved endoscope may be had from Messrs. Krohne & Sesemann, London, England.

## CANADA MEDICAL ASSOCIATION.

*Meeting at Halifax, 3rd Aug., 1881.*

In our last issue we gave our readers the Presidential Address. Of the meeting itself we now wish to speak. One thousand one hundred and ninety-one miles, the distance from Toronto to Halifax, is a long distance to travel; yet the interest held in the Association led four of our fraternity from Toronto, and four others from Ontario, to attend the meeting.

According to the statements of the fathers of the Association present at the meeting, some of whom have always attended (at least we are sure that Dr. Botsford has always been present), the recent meeting at Halifax was fully equal in interest and general success to any since the organization of the Association.

Our object, however, is more particularly to speak of the hospitality exhibited by the profession of Halifax. Too much cannot be said of their kind and courteous behaviour, not alone in the more public entertainments, but in the quiet and social way by which the visitors were made very comfortable and to feel at home. Whether it was being carried to a secluded spot along the shore of the magnificent harbour, where one could take a delicious header into the blue inviting salt water, or out in the offing in the broad Atlantic swells to catch the toothsome cod-fish, or behind a fast horse traversing the numerous and delightful roads through the splendid park, and along the beautiful north-west arm of the harbour, with elegant villas on either hand, or in the club, or the family circle, the Haligonian doctors displayed the soul of friendship and good cheer.

As to the journey to Halifax, a variety of routes were followed by the visitors. A good number went by the Gulf route, and found ample enjoyment. Some went or returned by way of St. John and Boston, and were well pleased. The President, Dr. Canniff, who travelled altogether by rail, tells us that he does not regret the taking of this route. But to make the journey enjoyable, one should not travel continuously. He should stop twice or thrice on the way to rest and enjoy the scenery. He may select, after passing Montreal, Quebec, Cacouna, Rimouski, Metapedia, Campbellton, Moncton, or

many other places on the way. The valley of the Metapedia, and along the Restigouche and the Bai de Chaleur, presents to the eye some of the most beautiful displays of Nature's grandeur.

The meeting next year will take place in Toronto, and we trust there will be no falling off in the attendance and interest hitherto manifested.

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THE PROFESSIONAL SCANDAL ARISING OUT OF THE PRESIDENT'S CASE.

It is very much to be regretted that in a case destined to become historical the profession should be so unfortunate as to be involved in a miserable scandal such as that of which the American medical periodicals have recently been full. In order that our readers may arrive at a just understanding of the merits we reprint from a Washington Journal—*Walsh's Retrospect*—Dr. Baxter's statement of his connection with the case:—

"I have been President Garfield's family physician for the past five or six years, and since his advent to the White House have continued to treat him professionally. Mrs. Garfield prefers homœopathic treatment, and in her recent illness I had no professional connection with her case.

"At the time the President was shot I was absent, having left the city twelve hours previous to spend a few days with a friend near Williamsport, Pa.; but on receipt of the news of his being shot, I returned by first express train, reaching Washington, Sunday, July 3rd, at 9 a.m.

"I went directly from the depot to the White House, and finding Dr. Bliss, said to him: 'Doctor, I have come to ask you to take me to see the President.' He replied: 'Well, I don't see the necessity of your seeing the President; I wish to keep him quiet.' Somewhat astonished at his reply, I said: 'I make the request as the President's physician. I have for years been his physician.' 'Yes,' replied Dr. Bliss, 'I know your game; you wish to sneak up here and take this case out of my hands.' I said: 'I wish nothing, Dr. Bliss, except what I am entitled to. If the President



prefers that you should take charge of the case I haven't a word to say.' 'Well,' said Dr. Bliss, 'you just try it on. I tell you that you can't do it. I know how you are sneaking around to prescribe for those who have influence and will lobby for you.' 'That is a lie!' I replied, whereupon he sprang to his feet, and his son coming across the room, placed his hand on his shoulder and said: 'I think I have something to say about this.'

"The impropriety of having any disturbance in a room next to that in which the President lay so grievously wounded at once came to my mind, and taking my hat I left the room, and have not since attempted to visit the President. I believe, as do other members of the profession in this city, that the treatment I received was discourteous in the extreme, and that in making the request I was fully justified by the code of medical ethics of the American Medical Association.

"I had no desire or intention to dispense with the medical services of Dr. Bliss in the case, but thought, as I was the physician of the President, I had a right to see him and take part in his treatment."

#### MEDICAL ASSOCIATION FOR QUINTE AND CATARAQUI.

On Friday, 12th August, a meeting of the medical gentlemen of the "Quinté and Cataraqui Division" met in the town of Picton, by appointment of Dr. H. W. Day, the Territorial Representative, for the purpose of establishing a Medical Association in said division.

Resolutions for the organization of the Association were adopted in accordance with the provisions of the "Ontario Medical Act."

Officers for the remainder of the year were elected as follows:—President, Dr. H. W. Day; Vice-President, Drs. Platt, Burdette, Metcalf, Beeman; Local Secretary for Quinté, Dr. Farley; for Cataraqui, Dr. Henderson; General Secretary and Treasurer for the Association, Dr. A. C. Bowerman, Bloomfield.

Dr. Wm. Canniff, of Toronto, delivered an able and interesting address on the "Destiny of Canada," before the York Pioneers, at their annual picnic, August 17th.

#### ANTISEPTIC OVARIOTOMY.

Listerism has lost its mainstay in abdominal surgery since it has now to be told that Keith, of Edinburgh, has at length abandoned its practice in ovariectomy in consequence of two deaths in his hands clearly traceable to carbolic acid poisoning. It will be remembered that some time ago we recorded Mr. Lawson Tait's recalcitrance shortly followed by that of Dr. Bantock, of the Samaritan Hospital. Keith's later defalcation will strike an almost fatal blow to the system in abdominal surgery. He now publishes a series of 46 successive successful cases without the spray to which Tait is able to add a series of thirty-one without a death.

WE heartily congratulate Dr. Billings, of the Surgeon General's department at Washington, upon his most excellent address before the International Medical Congress on "Our Medical Literature," and the high encomiums it elicited on all hands from the English medical press. The *Lancet* says: "No one could have foreseen that out of the material at his disposal he would have compiled an address remarkable even among all those of the past week for its ability, practical value, and wit. The large audience gathered to hear him was held charmed from beginning to end, both by his ever recurring flashes of American humour, and the striking nature of his facts and statistics."

BRITISH MEDICAL ASSOCIATION.—The forty-ninth annual meeting of this Association was held at Ryde, in the Isle of Wight, from the 9th to the 12th of August, both inclusive, under the Presidency of Mr. Benjamin Barrow, F.R.C.S. Notwithstanding that the meeting followed immediately upon the International Medical Congress, the attendance exceeded expectation, and the gathering proved a great and complete success. The address on Medicine was delivered by Dr. John Syer Bristowe, that in Surgery by Jonathan Hutchinson, and on Obstetric Medicine by Dr. Sinclair Coghill, of Ventnor. The 1882 meeting, being the Jubilee of the half century, will be held in Worcester, the Association's birth-place; that for 1883, in Liverpool; and for 1884, in Glasgow.

### TROMMER'S EXTRACT OF MALT.

We are glad to know that the extract of malt manufactured by this well-known and reliable firm still retains its well-deserved popularity, and is being largely used by our practitioners throughout Canada. There can be no question of the efficacy of the remedy in anæmic conditions from various causes, and our chief anxiety is to obtain a preparation that we can thoroughly rely upon. Our experience during the last few years convinces us that we can without hesitation, pronounce Trommer's Extract to be of this character.

WE take much pleasure in correcting an erroneous impression which has gone abroad through the medium of the lay newspapers, and, we are sorry to say, also certain American medical journals, that her Majesty had threatened to withdraw her patronage from the International Medical Congress if female doctors were to be allowed to participate therein. It now appears that the rumour was totally and entirely without foundation, and that the decision to exclude women was solely the result of the deliberate convictions of a large majority of the committee.

THE AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE—At the meeting of this Association recently held in Cincinnati, Canada bore away a full share of honours. Prof. Dawson, of Montreal, was elected President for the ensuing year; Prof. Daniel Wilson, of Toronto, Vice-President and Chairman of the Anthropological Section; Profs. Loudon and Pike, of University College; Prof. Wm. Osler, M.D., of McGill College; and Prof. P. C. Burpee, of St. John, were elected members; and Mr. Sanford Fleming was appointed to the special Committee on Standard Time.

We are gratified to observe that our fellow-countrymen and former fellow-citizen, Dr. A. E. Senkler, has been appointed Prof. of Pathology and Clinical Medicine in St. Paul Medical College; and we congratulate the college on having secured his services in these important branches, for we know his worth and are equally persuaded that his heart is in his work.

TORONTO SCHOOL OF MEDICINE.—In our notice of changes in this Institution in our last issue, we inadvertently omitted to mention that Dr. J. E. Graham, lecturer on Clinical Medicine and Dermatology, has been recently appointed Adjunct Lecturer on Practice of Medicine. Dr. Graham is at present at Newport, R. I., at the meeting of the American Dermatological Association.

THE August number of the *Monthly Magazine* publishes a formula for a new Styptic, which it attributes to the CANADIAN JOURNAL OF MEDICAL SCIENCE, but objects to its composition, on the ground that the proportion of carbolic acid might render its application poisonous. We direct the Editor's attention to the fact, that at page 405 of his April issue, the same formula is given, and no admonition added, otherwise we would have copied both together.

### CANADIANS ABROAD.

Wm. Ross Sutherland, M.D., McGill, became a Licentiate of the Royal College of Physicians on 28th July. Messrs. Thomas R. Dupuis, Kingston, and Rankine Dawson, of McGill College, have passed the primary examination of Royal College of Surgeons, England. Walter Franklin Chappell, M.B., Toronto, has been admitted a member.

The widow of the late Mr. Wm. Cawthra has donated the sum of \$500 to the Toronto General Hospital. It will be used in furnishing the "Cawthra Ward," in the wing built by the late Mr. Cawthra, and Messrs. Gooderham & Worts.

THE Fifth Annual Meeting of the American Dermatological Association began on the 30th August, and will be brought to a close to-day, September 1st., in Newport, R. I.

Dr. Paul F. Mundé succeeds Dr. Gaillard Thomas in the Chair of Obstetrics at the College of Physicians and Surgeons of New York. Thomas has been elected Emeritus Professor.

The American Surgical Association will hold its first regular meeting at Coney Island, on Sept. 13th, 14th, and 15th.



## Obituaries.

### HON. DR. BROUSE.

The sudden announcement of the death of the Hon. Dr. Brouse was a great shock to his numerous friends, very few of whom had heard of his illness. We are informed that he enjoyed good health during the summer, up to about Wednesday, 17th August, when he appeared to be suffering from an ordinary cold. On Friday his case became more serious, as he was attacked with erysipelas of the face, and lost strength rapidly. Pneumonia supervened, and he died Tuesday morning, August 23rd.

The deceased was a Canadian, born in the County of Dundas, in 1824. He graduated in Medicine in McGill College, in 1847, and received the degree of M.A. from the University of Victoria College in 1848. He was elected as the representative of the St. Lawrence and Eastern Division in the Ontario Medical Council in 1869, and retained this position until he resigned in 1879, but was at once appointed to represent the senate of Victoria College in the same body. He was elected Vice-President in 1869, and President in 1870. As a politician he represented South Grenville in Parliament from 1872 to 1878, when he was appointed senator.

He had a large and lucrative practice in Prescott until the year 1880, when he decided to leave that town, and go either to Toronto or Ottawa. After some hesitation he chose the latter city, and went there about a year ago. In Parliament and in the Senate he was a strong advocate of a Dominion Sanitary Bureau.

He was possessed of great energy and perseverance; was very successful in professional practice; always took a leading position in public medical matters, as, for instance, in the Ontario Medical Council; commanded the respect of all parties in politics; and, above all, was esteemed and beloved by those who knew him on account of his genial, kindly disposition, and affable manners in private life.

Dr. Mandl, the pioneer of Laryngoscopy, in France; Prof. Schleiden, of Frankfort, the illustrious Botanist and Physiologist; Dr. Bryk,

Professor of Surgery, in Cracow; Prof. Loze, of Berlin, author of General Pathology and Therapeutics as a Mechanical Science; and St. Clair Deville, the eminent Chemist, have passed over to the majority.

Dr. Bradford, of Manchester, the famous obstetrician, and collector and donator of the well-known "Bradford Library," has paid the debt of Nature at the age of four-score years. M. Chantreuil too, an eminent Parisian obstetrician, lately lecturing before the Faculty in place of M. Pajot, has succumbed to intestinal perforation.

## Book Notices.

*Sixty-first Annual Announcement of the Medical College of Ohio. Cincinnati, O.*

*Fortieth Annual Announcement of the St. Louis Medical College.*

*Announcement of the First Annual Session of the Medical Department of the University of Denver.*

*University of Bishop's College. Eleventh Annual Announcement of the Faculty of Medicine.*

*Annual Announcement of the St. Paul Medical College, Medical Department of Hamline University.*

*Glaucoma caused by Mental Worry.* By LEARTUS CONNOR, A.M., M.D., Detroit. (Reprint from *Detroit Lancet*).

*Notes on the Value of Carbo-Hydrates as Food and the Physiology of Starch Digestion.* By the TROMMER EXTRACT OF MALT COMPANY.

*Tubercular Laryngitis, or Laryngeal Phthisis.* By C. J. LUNDY, M.D., Prof. Diseases of the Eye, Ear, and Throat, Michigan College of Medicine, Detroit.

*Trichinæ: How to Detect them; How to Avoid them.* A popular account, intended for farmers, butchers, and consumers of Pork. By JOHN PHIN, Editor of the *American Journal of Microscopy*.

*Empysma and its Treatment by Valvular Drainage.* By A. M. PHELPS, M.D., of Chateauguay, N. Y. Read before Medico Chir. Soc. V., Montreal. (Reprint from *Canada Med. and Surg. Journal.*)

*On some of the Effects of the Chronic Impaction of Gall-Stones in the Bile Passages; and on the "Fievre Intermittente Hépatique" of Charcot.* By WM. OSLER, M.D., M.R.C.P., London; Prof. Institutes of Medicine, McGill College. (Reprint from *Medical Times and Gazette.*)

*Stenosis of Larynx, with Fibrous Adhesive Bands of the True Vocal Cords; Tracheotomy, Rupture of Bands and Cure of Stenosis by General and Local Treatment. Some remarks concerning the value of the Galvano-Cautery in the treatment of Diseases and Growths of the Naso-Pharynx.* By W. H. DALY, M.D., Pittsburgh. (Reprint from the Transactions of the American Medical Association, 1880).

*First Annual Report of the Astronomer in charge of the Horological and Thermometric Bureaus of the Winchester Observatory of Yale College.* 1880-'81. By LEONARD WALDO.

We learn from this report that during the year 1,957 certificates of thermometers of all classes have been issued; that of these, 1,667 were designed for physicians, use and physiological research. The result has been that instruments sent to them for certification have been found to be much more correct of late owing to the fact of their being liable to be subjected to this test, and to the observatory having loaned to makers standards for their guidance. The opinion is expressed that the great majority of physicians' thermometers now in use in the United States are from one-half to two degrees too high in their indications. There can be no longer any excuse for the use of an instrument whose degree of error is unknown.

#### APPOINTMENTS.

Thomas Norton, of the village of Horning's Mills, Joseph Carbert and James Henry, of the town of Orangeville, and Robert Lawrence, of the village of Mona Mills, Esquires, Doctors of Medicine, and Thomas Turnbull, of the village of Mono Centre, Esquire, to be coroners in and for the county of Dufferin.

#### Meetings of Medical Societies.

##### CANADA MEDICAL ASSOCIATION.

The Fourteenth Annual Meeting of the Canada Medical Association, was held in the Chamber of the Legislative Council, at Halifax, August 3rd and 4th.

The President, Dr. Canniff, of Toronto, called the meeting to order at 10.30 a.m., on the first day, about fifty members being present. The Hon. Dr. Parker, of Halifax, presented the report of the Committee of Arrangements.

On motion of Dr. D. Clark, seconded by Dr. Oldright, Dr. Strong, Superintendent of the Cleveland Lunatic Asylum, was elected a member by invitation. Dr. Strong, and the Ex-Presidents present were requested to take seats by the President. The Military and Naval Surgeons of Halifax were elected members by invitation.

Drs. MacDonald, Slayter, Harrington, Lanigan, Townshend, and Fitch were elected permanent members. The Secretary read a communication from the Sandy Cove Sea-bathing Company, offering the use of their baths to members of the Association and their families. It was decided on motion of Dr. Botsford, that the delivery of the President's address should be the first order of business at the afternoon session.

Dr. Reid, of Mount Asylum, Halifax, the Chairman of the Committee on Practice of Medicine, then read his report, in which he discussed general paresis. It was decided to have the discussion of the report immediately after the President's address.

Dr. Stewart, of Brucefield, read the Report of the Committee on Therapeutics. The discussion to take place after that of Dr. Reid's.

Dr. Oldright, of Toronto, gave a short verbal report from the Committee on Climatology and Epidemic Diseases.

The President read the Report of the Committee on Vital Statistics. It was decided to discuss the report at a future time.

On motion of Dr. Botsford, seconded by Dr. Hingston, the following were appointed the Nominating Committee, Drs. Robillard, Ross, and Fenwick, of Montreal; Eccles, of London; Dr. Clark, and Oldright, of Toronto; Lawson,



and J. F. Black, of Halifax; Steeves, of St. John; and Atherton, of Fredericton.

Dr. Hill, of Ottawa, read for Dr. Grant, a short paper, giving a description of a new and simple kind of stomach pump. Dr. Oldright described a simple stomach pump, worked on the principle of the syphon.

The Association adjourned a 1 p.m.

#### AFTERNOON SESSION, 2.45 P.M.

The President, Dr. Canniff, read his address on Medical Ethics.

On the conclusion of the address the discussion of Dr. A. P. Reid's paper was taken up.

Dr. Clark, of Toronto Lunatic Asylum, speaking of paresis, recommended that the general profession should make fuller study of that ailment, with a view to its treatment before it becomes incurable, which it generally is when it comes under treatment in lunatic asylums. He claimed that it was a disease with symptoms which could be detected long before it becomes incurable.

Drs. Jennings, Oldright, of Toronto; Botsford, of St. John; Morse, of Amherst; and others continued the discussion, and Dr. Reid summed it up as tending to show that if paresis could be diagnosed in its early stage, and the patient placed under the treatment of a specialist, it was not incurable.

Dr. Stewart's paper on Therapeutics was next considered.

Dr. Jennings opened the discussion, speaking of the treatment of diphtheria, claiming to have discovered the advantages of brandy in its treatment, though some one in New York claimed the discovery.

Dr. Hill addressed the meeting on the use of chloroform, claiming it was the best anæsthetic, and advised the administration of brandy before the anæsthetic.

Dr. Coleman had used ether and chloroform and from his experience considered the former far safer. The Americans showed the English that ether was safer and it had been substituted for chloroform in London hospitals.

Dr. Hingston, of Montreal, was strongly opposed to using chloroform and ether mixed. He showed the absolute necessity of having some one to watch the administration of the

anæsthetic entirely. He thought more were allowed to die under chloroform than there should be. Artificial respiration was one of the best means of restoration, but was not called for in many cases, because the trouble was not with the lungs, but the heart. In one instance he had reversed the patient, holding her feet up and head down, allowing the blood to run to the head. He considered ether safer than chloroform. Bromide of ethyl was useful where a short operation was to be performed, as it quickly brought insensibility, and consciousness returned as soon as the anæsthetic was withdrawn; but it was dangerous where a long operation was to be performed. Bi-chloride of methyl was useful where vomiting was to be avoided.

Dr. Jennings found in performing long operations, it was best to use chloroform till insensibility was obtained, and then to use ether.

Dr. Morse, of Amherst, attributed fatalities to long-kept or badly-made chloroform.

Dr. Atherton said in London many deaths, he believed, had resulted from too complicated apparatus and fear of the persons administering causing them to lose their self-possession. In Edinburgh there was none of the latter, and less death, though the chloroform appeared to be administered even carelessly. In treatment he seldom watched the pulse, believing the first danger was indicated by cessation of respiration. He described a case in point which Dr. Allen had asked for.

Dr. Stewart regarded failure to watch the pulse as dangerous, as very frequently the heart was most seriously affected.

Dr. Atherton said it might be well to watch respiration and the pulse too, but cessation of the former was the first dangerous symptom, and the attention should be concentrated on respiration.

Dr. Oldright, of Toronto, read a paper describing a simple syphon apparatus for drawing fluid from the chest, with a practical illustration and very full explanations of the use of the apparatus, and cited cases in which he found it successful.

Dr. Allen opened the discussion on this paper, giving his opinion that it was difficult to

prevent the admission of air while extracting fluids from the chest, and he advocated the use of the aspirator. He found, however, that cases in which air was admitted got on just as well as where the stringent means to prevent its admission were taken.

Dr. Jennings approved of the syphon principle, but thought a counter opening might be made, through which carbolized fluid might be passed, as the treatment of other abscesses.

Dr. Atherton advocated the use of carbolized air instead of washing out. The latter system has resulted in sudden death in some cases, and it was a question whether Dr. Oldright's system prevented this danger.

Dr. Farrell liked Dr. Oldright's method, but doubted whether it would ensure exclusion of air. He had adopted a somewhat similar plan, by the use of a rubber tube, in a case he recently had attended, but found the tube became occluded, and thought this difficulty would arise in using Dr. Oldright's apparatus.

Dr. Ross, of Montreal, approved of opening the chest on the antiseptic principle, but thought a large opening was preferable. He had seen cases of poisoning from the use of carbolic acid water.

Dr. Oldright closed the discussion, answering briefly the objections to his system, and claimed that its great advantage over all others was its ultimate result on the lungs, causing them to return to their natural condition.

The meeting adjourned at 6 p.m.

#### EVENING SESSION, 7.45. P.M.

Dr. Bessey, of Montreal, read a very instructive paper on vaccine, contending that the kine vaccine was the best, and that it was more or less liable to contamination when taken from humans. He makes a specialty of preparing kine vaccine in Montreal, keeping stock selected from the most healthy animals, and preparing the vaccine for use in the Dominion. After the paper was read a discussion ensued, and the reader answered many questions, the discussion lasting an hour. It was decided in the future to confine the discussion to ten minutes on each paper.

Dr. Worthington, of Clinton, read a paper

on *scarlatina maligna*, showing his experience in many cases and the success of cold water treatment.

After a short discussion on this paper, Dr. Fenwick read his paper on "Ovariectomy," citing many cases which came under his notice during forty years' practice.

Dr. Hill, and Dr. Somers discussed Dr. Fenwick's paper.

Dr. Hingston also read a paper on "Ovariectomy," which provoked a discussion, taken part in by Drs. Slayter, J. F. Black, and others, Dr. Hingston replying.

The Association adjourned at 11.10 p.m.

#### THURSDAY MORNING.

The Association met at 9 a.m.

The Treasurer's report was submitted, and Drs. Hill and Atherton were appointed auditors to examine and report upon it.

The Secretary, by direction of the President, exhibited some spruce shaving splints sent by Dr. Grant, of Ottawa.

Dr. Slayter exhibited an ingeniously contrived self-retaining speculum, which enables the surgeon in certain cases to dispense with the services of an assistant.

Dr. Macdonald read his paper on "Water Analysis." He showed chemicals and apparatus by which the purity or impurity of water can be detected, and described the qualitative and quantitative analysis of water. For the benefit of those who are not chemists, a ready method of water analysis was described, by which any person could examine drinking water and detect impurity in five minutes. The paper was considered of so much importance that Dr. Macdonald was requested to publish it in the *Medical Journals*, which the Association consented to do.

In the discussion which followed, Dr. Coleman, of St. John; Dr. Hill, of Ottawa; Dr. Oldright, of Toronto, took part.

Dr. Wright exhibited, for Dr. Grant, of Ottawa, a number of spruce shaving splints, which he found very convenient and useful in the treatment of fractures.

Dr. Stewart, of Brucefield, read a paper on "Treatment of Exophthalmic Goitre by ergot,"



and, at its conclusion, replied to questions by Drs. Steeves and Coleman.

Dr. Coleman read a paper on "The use of the Ophthalmoscope in the diagnosis of brain disease." He cited several cases and their mode of treatment, and his success in such treatment.

Dr. Jennings read a report of some cases in practice, showing the effect on the temperature of a patient on a water bed by using hot or cold water; also some cases showing the effect of constant irrigation with carbolized water as compared with the ordinary Listerian spray and gauze. At the same time he exhibited an instrument used in the process of irrigation, which was worked on the syphon principle.

The accounts of the acting General Secretary, Dr. A. H. Wright, for \$11.39, and of the Local Secretary, for \$21.40, were ordered to be paid.

Dr. Slayter introduced the following resolution by way of notice:—

"Whereas, The system of specialism and specialists, which at present obtains to a certain extent in the Dominion, and which has developed to a very large proportion in the neighbouring Republic, is for the most part the outgrowth of superficial professional education and want of success as practitioners of medicine and surgery:

"Therefore resolved, That it is the opinion of the society, that specialism should be discountenanced by the members of this Society, and the specialists should be treated and looked upon as irregular practitioners, except in rare cases, where long experience, extended study, and peculiar aptitude has placed a medical man in a special position toward his brethren:

"Be it therefore resolved, That the members of this Society pledge themselves to do all in their power to check the growth of this species of evil."

In supporting his resolution, Dr. Slayter said, the evil complained of was ruining their profession in America, and must be stopped if they ever expected to come up to the European standard.

Dr. Farrell spoke of the difficulty of the doctors getting together in these annual meetings, as now held, and thought the smaller societies in the Maritime Provinces should be consolidated into a branch of the Dominion Association. He moved that a committee be

appointed to consider the matter and confer with the various provincial medical societies for the purpose of bringing about a plan of organization of the medical societies in the Dominion in connection with the Dominion Medical Association. Drs. Clark, Caniff, Hill, Fenwick, Hingston, Steeves, Atherton, J. F. Black, Farrell, and the Secretary were appointed such committee.

Dr. Fenwick moved, notice having been given last year by Dr. Howard, that the by-law relating to fees be amended, so as to read thus: "That every member shall pay two dollars for every meeting he shall attend." The motion was carried.

Dr. Page made a short speech on sanitary legislation, and moved that Drs. Canniff, Oldright, Grant, Hill, Brouse, Osler, Fenwick, Larocque, Botsford, Atherton, Parker, and J. W. Macdonald, be a committee to seek from the Dominion Government improved legislation in respect to sanitation, and vital statistics, and to insist upon the organization of the profession as a condition of political support at the next election.

The motion passed.

On motion of Dr. J. F. Black, seconded by Dr. Slayter, the Committee on Public Health was instructed to hold a conference with the committee on the same subject of the Nova Scotia Medical Society.

It was decided to defray the travelling expenses of the Secretary and Treasurer from the funds of the Association.

The President of the Association having announced that Dr. A. H. David had withdrawn from the office of General Secretary of the Association, a resolution was passed expressive of the Association's deep regret that any cause should prevent him from continuing his services, and more especially that this cause should depend upon personal indisposition. The success of the Association had heretofore largely arisen from the steady and persevering efforts of Dr. David, and the Association trusted that he might for many years witness the continued success of an institution to which he had been so devoted.

The auditors, Drs. Hill and Atherton, reported having carefully examined the Treasurer's

accounts, which they find to be intelligently and well kept and quite correct. They show \$138.35 received since last September, and \$133.66 expended, leaving a balance on hand of \$4.69.

Dr. Oldright gave notice that at the next meeting he would move that clause 10 of by-laws should be amended by substituting the words, "Public health, vital statistics, and climatology," for the words, "Climatology and epidemic diseases."

The Committee on Nominations recommended the following-named officers:—

President Dr. Fenwick, of Montreal.

General Secretary—Dr. W. Osler, of Montreal.

Treasurer—Dr. E. Robillard, of Montreal.

Vice-President of Ontario—Dr. D. Clark, of Toronto.

Local Secretary of Ontario—Dr. A. H. Wright, Toronto.

Vice-President of Quebec—Dr. F. W. Campbell, Montreal.

Local Secretary of Quebec—Dr. Belleau, of Quebec.

Vice-President of Nova Scotia—Dr. R. S. Black, Halifax.

Local Secretary of Nova Scotia—Dr. C. D. Rigby, Halifax.

Vice-President of New Brunswick—Dr. P. R. Inches, St. John.

Local Secretary of New Brunswick—Dr. C. Holden, St. John.

*Committee on Arrangements.*—Drs. D. Clark, Oldright, Temple, A. A. McDonald, of Toronto, with power to add to their number.

*Committee on Necrology.*—Drs. Fulton, of Toronto; Atherton, of Fredericton; Lachapelle, of Montreal.

*Committee on Education.*—Drs. Eccles, London; Holmes, Chatham, and Bessey, Montreal.

*Committee on Climatology and Public Health.*—Drs. Botsford, St. John; Worthington, Clinton, Ont.; Larocque, Montreal; McDonald, Londonderry, and Coleman, St. John.

*Committee on Ethics.*—Drs. Canniff, Toronto; Malloch, Hamilton; Gardner, Montreal; Marsden, Quebec; Bayard, St. John; Parker and W. J. Almon, Halifax; Steeves, St. John; Beaudry, Montreal, and Charles Moore, Sen., London.

*Committee on Publication.*—Drs. Ross, Montreal; Cameron and Fulton, Toronto; the General Secretary and Treasurer.

*Committee on Practice of Medicine.*—Drs. Lawson, Halifax; Graham, of Toronto; Duncan, of Bathurst.

*Committee on Surgery.*—Drs. Shepherd, of Montreal; J. F. Black, of Halifax, and McFarlane, of Toronto.

*Committee on Obstetrics.*—Drs. Temple, of Toronto; Trudel, of Montreal, and McLaren, of St. John's.

*Committee on Therapeutics.*—Drs. Tye, of Thamesville; Wilkins, of Montreal, and Somers, of Halifax.

Toronto to be the next place of meeting.

The report was adopted, and the first Wednesday in September, 1882, chosen as the date.

Votes of thanks were passed to railway and steamboat companies, the Local Government for the use of the Council Chamber, the Sandy Cove Bathing Company, the local medical men, and to the Acting Secretary, Dr. Wright.

The President then left the chair, which was taken by the President-elect, Dr. Fenwick, who thanked the Association for the honour conferred upon him.

On motion of Dr. Hingston, a vote of thanks was passed to the retiring President for his able conduct in the chair, and his admirable address, containing so many useful and practical hints. This was acknowledged by Dr. Canniff, amidst applause.

The Association adjourned at 12 o'clock to allow the members to attend the Excursion and Dinner given by the Profession of Halifax, and the Commissioners of Public Charities.

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## Miscellaneous.

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ANENT doctor's signs, the *N. Y. Record* says: The brazen sign is large; it covers the whole door post, it stretches from window to window; its lettering is brilliant, and it is set off with scroll-work in the corners; the passer-by sees it, and cannot but read it; small boys shout out the name as they go by, and adults mutter it over till they reach another block. It is judiciously placed so that the street-lamp illumines it at night. It affects the more public ways, and it indicates the astute and enterprising physician. He is one who maintains a dignified equipoise between the code which says, "Thou shalt not advertise," and the Bible which says, "Let thy light so shine." In these days, when aestheticism is in the ascendant, when



every man of thorough culture lunches at least once a week on the sight of a lily, it would be strange if a love of the beautiful did not affect the style of that corner slab of modern civilization—the subject of this discourse. The *Æsthetic Sign*, in its supremest development, consists of a black marble slab, in which the physician's name is carved and gilded. When especially "intense," the letters are old Roman, with golden punctuation marks, which delicately suggest to the looker-on that he come to a full stop. Some superficial critics have already classified these evidences of the union of the beautiful with the pilular, as "mortuary signs"—a name which is uncanny and which stamps its user as a Philistine. — *Canada Medical and Surg. Journal*.

**HYGIENE OF THE INFECTIOUS FEVERS.**—The Forfarshire Medical Association recently declared: "That the Association, having considered the desirability of promoting uniformity of practice amongst its members in their management of infectious fevers with respect to the period of time during which quarantine precautions should be maintained, recommend as follows:—When an infectious fever has appeared in one or more members of a household, other members who may have been exposed to the chance of infection, by intercourse with them or otherwise, should not be removed to a household where there are others liable to be infected, until the expiry of the period of incubation shows that they have escaped. Without going to extremes, the period of incubation may, for practical purposes, be considered to be: for small-pox, typhus, whooping-cough, measles, fourteen days each; and scarlet fever and diphtheria, ten days each. That convalescents from these fevers should be considered as still liable to give off infection until the expiry of time, counting from the beginning of the illness, ranging for each fever as stated below:—Small-pox, fourteen days after the termination of scabbing; typhus, twenty-eight days from inception; scarlet fever, seven weeks from inception; diphtheria, six weeks from inception; whooping-cough eight weeks from inception; measles, six weeks from inception.—*British Medical Journal*.

**PRURITUS—GELSEMINUM.**—Dr. L. D. Bulkley (*New York Med. Jour.*, 1881, p. 30), uses gelseminum. Beginning with ten drops of the tincture, if in half an hour the itching is not relieved, and there are no toxic symptoms, as languor, the remedy is repeated in the dose of twelve or fifteen drops, and so on until results are obtained, or until a drachm or so has been taken in two hours. He has never pushed it to any of the severer symptoms, and has often found relief after the first dose.—*Quarterly Epitome*.

**ATROPINE IN MENORRHAGIA AND HÆMOPTYSIS.**—Tacke (*Berliner klinische Wochenschrift*, No. 6, 1881,) having had occasion to prescribe sulphate of atropine hypodermically in a case of wandering eczema, found that the patient's menstruation, which had been hitherto excessive, became and continued moderate after the first hypodermic injection. He subsequently had a similar experience with two other cases, and a case of hæmoptysis was also markedly improved, whence he concludes that atropine hypodermically administered, is as valuable a remedy against menorrhagia and hæmoptysis as ergot, and as it is not so liable to cause inflammation of the subcutaneous cellular tissue, as the latter, it is much more easily administered hypodermically, thus avoiding any tendency to gastric or intestinal disturbance.—*Quarterly Epitome*.

## Births, Marriages, and Deaths.

### BIRTHS.

At 97 Bond street, on the 14th August, the wife of Dr. E. J. Barrick, of a son.

At Prince Arthur's Landing, August 23rd, 1881, the wife of Thos. S. T. Smellie, M.D., of a daughter.

### DEATHS.

At Ashleigh Grange, Colborne, the residence of his brother, Dr. Willoughby, George R., youngest son of George H. Willoughby, aged 28 years.

On Tuesday, the 23rd day of August, 1881, at the Russell House, Ottawa, of erysipelas and pleuropneumonia, after a short illness, the Hon. William Henry Brouse, M.A., M.D., member of the Senate of Canada, aged 57 years.

On the 7th Aug., at Waldemar, Tyrrel Eyre Jessop, only child of Dr. Frank Strangways, of Beeton, aged 4 months and 14 days.

### MARRIAGES.

On the 17th ult., by the Rev. H. S. Matthews, at the residence of the bride's father, Samuel Jefferson, of Albion, to Mary Jane Strangways, daughter of F. T. Strangways, Esq., J.P., of Tecumseth, and sister to Dr. Strangways, Beeton.

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TORONTO, OCTOBER, 1884.

## Original Communications.

### ON WATER ANALYSIS.

BY J. W. MACDONALD, M.D., F.R.C.S.E., MEDICAL  
OFFICER TO THE STEEL CO. OF CANADA.

[Read before the Canada Medical Association.]

I am frequently asked by both medical men and laymen to give some ready methods by which the fitness or unfitness of water for domestic purposes may be ascertained. In answering the question several difficulties present themselves. The cost of apparatus for a complete examination of water is a serious matter; few persons have the time or the inclination to carry out detailed chemical analyses, and lastly a conclusion as to the purity or impurity of water must be based upon a collation of all the evidence that can be obtained, rather than from the results of one or two tests. The vital importance of the subject, and the lively interest which is being awakened in regard to it, have led me to attempt the description of water analysis, which will be sufficient for ordinary purposes, and at the same time fall within the means and opportunities of every medical practitioner. Two years ago I imported from Savory & Moore, of London, one of Parke's Cabinets for water analysis. It cost me, inclusive of duty, about one hundred and fifty dollars, and nearly one-half the contents were destroyed by breakage. As few would feel disposed to go to that expense, I have endeavoured to meet the difficulty by preparing a small, cheap, and at the same time efficient case of chemicals and apparatus which should not cost more than

twelve or fourteen dollars. The case is eighteen inches long, five inches wide, and nine inches high. Inside it contains the following chemicals in three ounce bottles.

Standard Solution of Nitrate of Silver.  
Sol. of Yellow Chromate of Potash.  
Solution of Soap.  
Solution of Nitrate of Barium.  
Two shaking bottles for soap test.  
Nessler's Solution.  
Dilute Sulphuric Acid.  
Solution of Iodide of Potassium and Starch.  
\*Oxalate of Ammonium.  
Standard Solution of Ammonium Chloride.  
Standard Solution of Permanganate of Potassium.

The apparatus consists of—

1 Flask with ring for boiling.  
2 India rubber caps with two necks.  
1 retort stand.  
1 Burette with clasp.  
India rubber tubing.  
Spirit Lamp.  
5 test tubes.  
Glass rod.  
Glass measure 50 C.C.

IN THE EXAMINATION OF WATER, the coarser physical characters, such as colour, smell, taste, and transparency, should first be noted. The colour is best observed by pouring the water into a tall glass vessel and looking down upon it. Perfectly pure water has a bluish tint and the bottom of the vessel is clearly seen through several feet of water, while some waters are so turbid as to obscure the bottom when only a few inches are looked through. A green color as a rule indicates vegetable impurity, a yellow or brown color, (excepting in peat water) animal impurity. Smell is best observed by warming, boiling, or

distilling the water, when characteristic odors are frequently given off.

The evidence derived from an examination of the physical characters is very unreliable, we must, therefore, proceed to an examination of the dissolved solids, which gives us the most valuable evidence. The examination is divided into the Qualitative and Quantitative :

I. QUALITATIVE. The most useful tests are the following:—

SUBSTANCES SOUGHT FOR	RE-AGENTS TO BE USED, AND EFFECTS.
Reaction .....	Litmus and turmeric papers: usual red or brown reactions.
Lime .....	Oxalate of ammonium: white precipitate.
Chlorine .....	Nitrate of Silver and Dilute Nitric Acid: white precipitate becoming lead color.
Nitrous Acid. ....	Iodide of Potassium and Starch in Solution: a blue color.
Ammonia .....	Nessler's Solution: a yellow color or yellow brown precipitate.
Nitric Acid .....	Sol. of Sulphate of Iron and pure Sulphuric Acid: olive colored zone.
Oxidisable Matter including Organic Matter.....	Permanganate of Potassium: red color disappears.

## II. QUANTITATIVE:

1. DETERMINATION OF CHLORINE.—Prepare a solution of Nitrate of Silver, by dissolving 17 grammes in one litre of water.

Take 100 C.C. of the water to be examined, place it in a white porcelain dish; add enough solution of yellow chromate of potash to make it just yellow. Then add the nitrate of silver solution from a burette, and stir. A red color is produced, which disappears as long as any chlorine is present. Stop when the least red tint is permanent, then read off the number of C.C. of silver nitrate used; each of these represents 3.55 milligrammes of chlorine. Multiply by 10 to give the amount per litre, and this again by .07 for grains per gallon. Chlorine in water is very suspicious of the presence of the liquid excreta of men or animals. If in addition we find nitric and nitrous acids, ammonia and phosphoric acid, the evidence is very strong. Chlorine, however, may be due to strata containing chloride of sodium or calcium. In this case the water is alkaline from sodium carbonate. In some cases the chlorine is due to impregnation from sea water. It is then large in quantity; there is also magnesia and little evidence of organic matter.

2. HARDNESS.—This is estimated by Clarke's soap test, and by it we determine—

1. TOTAL HARDNESS, representing the aggregate earthy salts and free carbonic acid.

2. THE REMOVABLE HARDNESS, or that which disappears on boiling.

3. THE PERMANENT HARDNESS, which is unaffected by boiling.

By the soap test can also be determined the amount of certain constituents, such as lime, magnesia, sulphuric acid, and free carbonic acid.

APPARATUS REQUIRED FOR THE SOAP TEST.—Measure of 50 or 100 C.C. Burette divided into 10ths of a cubic centimetre, two or more stoppered bottles to hold about four ounces. We also require the following solutions :

1. STANDARD SOLUTION OF BARIUM NITRATE. Dissolve .26 grammes of pure barium nitrate in 1 litre of water or 18.2 grains to 1 gallon. A concentrated solution of ten times this strength may be made and diluted with nine parts of water when used.

2. SOLUTION OF SOAP. Dissolve a piece of soft potash soap, of the British Pharmacopoeia, in equal parts of water and alcohol; filter, and then graduate as follows :

Put 50 C.C. of the Standard Solution of barium nitrate into the shaking bottle, and add to it slowly the soap solution from the finely-graduated burette. After each addition shake vigorously and place the bottle on its side. Continue this until you have a thin beady lather over the whole surface, permanent for five minutes. Read off the amount of soap solution used; if exactly 2.2 C.C. have been taken the solution is correct; if less, the soap solution must be diluted with spirit and water. The amount of dilution can be ascertained by a simple rule. Suppose 1.8 C.C. have been used and the whole of the unused solution measures 200 C.C. then

$$\begin{aligned} \text{As } 1.8 : 2.2 &:: 250 : x \\ x &= 244.4 \text{ C.C.} \end{aligned}$$

The 200 c.c. must then be diluted with equal parts of spirit and water to 244.4 C.C.

With these solutions, and having all glasses, burette, etc., perfectly clean—for the least quantity of acid would destroy the accuracy of the process—we can proceed as follows :

1. To determine the total hardness of the water. Take 50 C.C. of the water in a stoppered bottle, and add the soap solution from the burette, shaking strongly after each addition until a lather permanent for five minutes



spreads over the whole surface without any break.

Then read off the number of tenths of soap solution used.

From this number subtract 2, as that quantity is necessary to give a lather with 50 C.C. of the purest water. The soap solution which has been used indicates the hardness due to all ingredients which can act upon it; as a rule they are lime, magnesian salts, iron, and free carbonic acid.

It is usual to express this hardness by degrees of Clark's Scale. Though dependent upon various causes it is considered as so much calcium carbonate per gallon, one grain of calcium carbonate per gallon being one degree of Clark's Scale.

The calculation is as follows: Each tenth of the Soap Solution corresponds to .25 milligrammes of calcium carbonate. Multiply this co-efficient by the number of tenths of soap solution used and the result is the hardness of 50 C.C. Multiply by 20 for the amount per litre, and by .07 for grains per gallon, or degrees of Clark's Scale.

To obtain the PERMANENT HARDNESS.—Boil a known quantity briskly for half an hour, replacing the loss with distilled water from time to time; cork the vessel and allow it to cool. Then determine the hardness in 50 C.C. as before.

REMOVABLE HARDNESS. This is very easily calculated, for we have only to take the difference between the total hardness and the permanent hardness and express the result as removable hardness.

The permanent hardness is the most important, for it represents the most objectionable earthy salts, viz.: calcium sulphate and chloride, and the magnesium salts. The permanent hardness of good water should not exceed 3° or 4° of Clark's Scale.

The next step in our investigation is the Determination of Free or Saline Ammonia, and of Nitrogenous Organic matter.

AMMONIA in water is chiefly derived from organic substances, either vegetable or animal. In the detection and estimation of Ammonia,

the very delicate test known as Nessler's Solution is of the greatest value.

NESSLER'S SOLUTION is thus prepared: Dissolve 50 grammes of Iodide of Potassium in 250 C.C. of distilled water; reserve a small quantity, warm the larger portion, and add a strong aqueous solution of corrosive sublimate until the precipitate ceases to disappear; then add the reserved solution of Iodide so as to just dissolve the red precipitate; filter, and add to the filtrate 200 grammes of solid potash dissolved in boiled water. Dilute to 1 litre, and add 5 C.C. of a saturated aqueous solution of mercury bi-chloride. Allow to subside; decant the clear liquid and keep in a dark place.

In addition to this liquid we require—

STANDARD SOLUTION OF AMMONIUM CHLORIDE, which is of the strength of .0315 grammes to 1 litre of water. Each C.C. represents .01 milligrammes of Ammonia. The mode of procedure is as follows: Place in a flask 250 C.C. of the water to be examined; distil off about 120 C.C.; measure this distillate carefully; test a little with Nessler's Solution in a test tube, and observe the colour; if not too dark, take 100 C.C. of the distillate and put it into a cylindrical glass vessel and place it upon a piece of white paper. Add to it  $1\frac{1}{2}$  C.C. of Nessler. Put into another similar cylinder as many C.C. of Ammonium Chloride as may be thought necessary, and fill up to 100 C.C. of pure distilled water, which has previously been proved to be free from Ammonia; drop in  $1\frac{1}{2}$  C.C. of Nessler. If the colours correspond, the process is finished, and the amount of Ammonium Chloride used is read off. If the colors are not the same, add a little more Ammonium Chloride, so long as no haze shows itself; if it does then a fresh glass must be taken and a new trial made. When the colours correspond, read off the C.C. of Ammonium Chloride used; allow for the portion of distillate not used, multiply by .01, and we have the number of milligrammes of free Ammonia in the 250 C.C. acted upon, multiply this amount by 4 and we have the number of milligrammes per litre.

EXAMPLE.—From 250 C.C. of water, 123 were distilled, 100 C.C. were taken for the experi-

ment; 4.5 C.C. of Ammonium Chloride were required to give the proper color; then  $4.5 \times \frac{128}{100} \times .01 \times 4 = 0.2214$  milligrammes of free ammonia per litre.

The free Ammonia or Saline Ammonia is the Ammonia combined with Carbonic, Nitric or other acid, and also what may be derived from any easily decomposable substance such as urea. The quantity should not exceed .02 milligrammes per litre in good water.

Having calculated the free ammonia, the residue of the water in the retort is used to determine the nitrogenous organic matter as measured by albuminoid ammonia. The nitrogen is converted into ammonia by means of potassium permanganate in presence of an alkali; the ammonia is then distilled off and estimated as above.

Dissolve 8 grammes of permanganate of potassium, and 200 grammes of solid caustic potash, in one litre of water; boil thoroughly to drive off any ammonia and destroy any nitrogenous matter. This is known as Wanklyn's Solution. Add to the residue in the retort 25 C.C. of this solution; distil over 110 to 120. Calculate the ammonia as before and state the results in this case as ALBUMINOID AMMONIA.

The standard limit of Albuminoid Ammonia in good water is stated by Wanklyn to be .05 milligrammes per litre; some other authorities place it at .08. Much albuminoid ammonia, little free ammonia and almost entire absence of chlorides, is, according to Wanklyn, indicative of vegetable contamination.

#### OXIDISABLE MATTER.

The chief sources of oxidisable matter in water are oxidisable organic matter, and nitrous acid as nitrates. The estimation of these affords valuable evidence of the character of a water, and are conveniently determined by means of permanganate of potassium.

We calculate: 1. TOTAL OXIDISABLE MATTER in terms of oxygen required for its OXIDATION. Make a solution of permanganate by dissolving .395 grammes of the crystallized salt in one litre of water. Each C.C. of this solution yields 0.1 milligramme of oxygen in presence of an acid. Test its accuracy by a solution of

crystallized oxalic acid of the strength of .7875 grammes to the litre of water. This solution, acidulated with dilute sulphuric acid, should exactly decolorize an equal quantity of solution of permanganate.

The process, as recommended by Woods, is as follows:

"Take a convenient quantity of the water to be examined, say 250 C.C.; add 5 C.C. of dilute sulphuric acid (1 to 10); drop in the permanganate solution from a burette, until a pink colour is established; warm the water up to 140° F., dropping in more permanganate if the color disappears; when the temperature reaches 140, remove the lamp; continue to drop in the permanganate till the color is permanent for about ten minutes. Then read off the number of C.C., and multiply by 0.1, to get the milligrammes of Oxygen, and by 4 to get the amount per litre." The amount of oxygen obtained by this process includes that from organic matter and nitrous acid. To separate these we must drive off the nitrous acid by boiling with sulphuric acid as follows:

Take 250 C.C. of the water under examination; add 5 C.C. of dilute sulphuric acid, as before; boil briskly for 20 minutes, then allow it to cool down to 140° F.; add the permanganate solution until a pink color remains for ten minutes; then calculate as before. The result in this case must be stated as milligrammes per litre of oxidisable organic matter, or ORGANIC OXYGEN.

NITROUS ACID is now easily determined, for it is represented by the difference between the two preceding processes. Each milligramme of oxygen is equivalent to 2.875 milligrammes of nitrous acid, the difference must, therefore, be multiplied by this factor, and the result is nitrous acid in milligrammes per litre.

From the foregoing tests we can gain sufficient evidence to form an opinion of the character of a given sample of water. The inference from this evidence can be drawn as follows:

A large quantity of nitric and nitrous acids, much oxidisable and nitrogenous organic matter, with much chlorine, indicates recent sewage impregnation. With little oxidisable organic matter, and nitric acid in large amount, we



assume that more or less complete conversion of organic matter has taken place. Albuminoid ammonia, and nitric acid in abundance, and free ammonia and chlorine in small amount, is indicative of vegetable contamination. Little chlorine, with much albuminoid, and free ammonia, nitrous and nitric acids show contamination from gaseous emanations.

To those who have not the inclination or the opportunity to carry out an analysis such as I have described, a few ready tests may be useful. Any druggist can prepare from the formulæ already given, the following solutions: nitrate of silver, Nessler's solution, solution of permanganate of potassium, and solution of iodide of potassium and starch. Provided with these they can proceed as follows:

1. Observe the colour.
2. Observe the smell, particularly when the water is boiling.
3. The taste.
4. Add to a small quantity of the water, in a test tube or wineglass, a little of the solution of nitrate of silver. If it give a white colour, it contains chlorides. This is a very suspicious sign.
5. To another portion of the water, add a small quantity of Nessler's Solution. A yellow colour or yellow brown precipitate shows the presence of Ammonia.
6. Add a few drops of the solution of permanganate of potassium. The pink colour remains if the water is pure; it disappears if the water contains organic matter.

These simple tests would in most cases settle the question of the purity or impurity of a suspected water.

The amount of disease and suffering caused by the use of impure water, is, in this country, assuming terrible proportions. Epidemics of typhoid and other zymotics are constantly occurring, which could be easily prevented by a little care in examining the water, and discontinuing the use of impure wells. This is one of the evils arising from the want of public health legislation. Surely the day is near at hand when our Legislature will protect the lives of our people from this, as it does from other forms of poisoning, and furnish us

with the means whereby we can control the causes of preventible disease. Then shall we gain a happy victory over those dread enemies which are desolating the homes and destroying the lives of so many of the brave sons and daughters of this prosperous Dominion.

### PRIMARY TUBERCULOSIS OF THE LARYNX.

BY L. L. PALMER, M.D., C.M., TORONTO, SURGEON  
EYE, EAR, AND THROAT.

(Read before the Ontario Medical Association, in Toronto,  
June 1st, 1881.)

M. N., æt 28, unmarried, clerk in a store; complained of having had an attack of hoarseness, and some soreness of throat two months. When he came to me Jan. 6th, 1881, he stated that during this time he had suffered pain on deglutition, and hoarseness which now was very marked, but not amounting to aphonia; during this interval he had improved very much, so that he considered himself almost well, but after Christmas he went to the skating rink, where he took cold, and immediately grew worse. During no part of this time had he the slightest cough, nor any symptom of chest affection; temp. 99° F; pulse, about 92; respiration, 21. On careful auscultation and percussion, I found no abnormal sounds audible. Laryngoscopic inspection however disclosed the characteristic picture of a Phthisical Larynx with the exception that there was not that marked pallor that is generally present.

The whole mucous surface of the larynx was much swollen. The epiglottic folds looked like two large solid pyriform tumors—the larger ends being against each other in the median line, to such an extent that the inter-arytenoid fold was lost in the swelling, and the small ones directed upwards and outwards; the epiglottis was much swollen and turban-like; vocal cords were red, and seen peeping out underneath the much swollen ventricular bands, and the mucous membrane of all these parts was intensely red, with several points of small ulceration on the free margin and under-surface of epiglottis and arytenoid cartilage of right side. I considered these appearances, though exceptional in color, in all other respects

sufficiently typical to enable me to diagnose it without a doubt tubercular laryngitis—the whole was overlaid with pale, pultaceous deposit.

The patient visited my office frequently and regularly without any marked improvement, though he experienced marked relief from anodyne inhalations of *co. tinc. benzoin conium* and local applications of boracic acid and morphia, after which deglutition was rendered less difficult. New points of ulceration continued to form, and those already existing, gradually coalesced, forming serpiginous ulcers on the epiglottis and aryepiglottic fold, this condition continued to progress, until these ulcers with one another, and with others coalesced, and on the 21st of January, I first discovered on physical exploration of the chest, dullness at the right apex with faint bronchial respiration. The left side still gave normal sounds. This diagnosis was corroborated by another medical man after a careful examination; the pulse now beat about 100, and the temp. was 101° F. This abnormal condition gradually and rapidly extended over the right lung, and soon invaded the left side. Cough also became troublesome, and other symptoms of active tuberculosis, which soon confined the patient to the house; and finding local treatment afforded him no benefit other than a measure of relief, I advised him to go to his home in the country, where I learn he died a few days since.

I regret, gentlemen, that previous to Jan. 21st, I did not have other medical men to auscultate this patient, that I might have the satisfaction of presenting an opinion corroborative of my own. But in the absence of this, we may, perhaps, assume without arrogance, that the diagnosis was correct; and if so, we have then a case of tuberculosis of the larynx, with an *apparently* normal condition of the lungs. I say *apparently*, normal, for in the present state of our knowledge on this subject, and in the absence of a *post mortem* at this particular stage of the disease, we cannot speak more positively. Every practical physician knows the difficulty, indeed the impossibility sometimes, after the most careful physical examination, of detecting small cheesy deposits

or indurated spots in the lungs, especially when they are of long standing and deeply situated. This, associated with a second difficulty, as asserted by Dr. Heinze, of diagnosing by the laryngoscope, with absolute certainty the existence of tubercle in the larynx, and these with a third, in securing a *post mortem* at a stage when the larynx is believed to be tuberculous while the lung is not, will doubtless for some time keep the question of *primary tuberculosis* of the *larynx* wrapt in the mist of uncertainty.

Therefore the faithful report of cases carefully investigated, will ever be of value in throwing light on this subject, and clearing up a large and interesting pathological question, as well as one of practical bearing.

The theory asserted by some authorities of eminence, first and foremost amongst these, Louis, of Paris, that the ulceration of the larynx is to be attributed to the corroding effect of the sputa of pulmonary phthisis, seems quite opposed by the history of this case, and cannot hold good, for the laryngeal ulceration existed when there was no sputa other than the product of the larynx, and when there was no cough, as was the case during the first two weeks he was under my observation, and as he asserted was the case prior to this.

Recent researches of such men as Wendt, Isambert, and Heinze have made such advance in the pathological study of tuberculosis, as affecting the larynx, that laryngoscopists consider it now an accepted fact that tubercle does exist, and does pass through its pathological phases in these regions, and here it takes its seat, as it does in the omentum, intestine, spleen, and other organs of the body, in a certain sense, *de novo*, if not independently of its existence elsewhere.

Dr. Seiler, of Philadelphia, has reported a case in which he was called upon to make a *post mortem*, in his capacity as pathologist to the Presbyterian Hospital in that city. The patient died with all the symptoms of typhoid fever; she was a young coloured woman of eighteen to twenty years of age. Upon examination he failed to find evidences of typhoid fever, but he found tubercular deposits all through the mesenteric glands, intestines, and



omentum, in fact throughout all of the viscera except the lungs; the larynx was perfectly sound.

With such instances before us I think it is safe to assume that we may yet have more clearly demonstrated to us that we may, and do have *primary* laryngeal phthisis with no pulmonary lesion. The larynx is the common seat of catarrh, especially in variable climates. If catarrhal changes were developed underneath the mucous membrane—in the mucosa and submucosa of the larynx, we have, as far as the larynx is concerned, a condition in which tubercles are more readily deposited. May there not then under such predisposing conditions, be a tendency to an early deposit of tubercle in the larynx, while the lung remains intact? I would urge my belief, that in certain cases phthisical lesions *can* be detected in the larynx before there is any evidence of their existence in the lungs; these lesions are due to a peculiar infiltration of cells; and this obtained in the case which I have taken up your time to report, not so much to insist that it was a case of primary tuberculosis of the larynx, as to elicit the opinion and expression of others, and, perhaps, draw out a full discussion of the subject.

The following discussion took place after the reading of the paper:

Dr. Graham dissented from the idea of the existence of tubercle in the larynx apart from the lungs. It was possible to have disseminated tubercle existing in the lungs without being discovered by physical examination.

Dr. McDonald, of Hamilton, said that he had had cases, and *post mortems*, in which with very doubtful physical signs of chest affection, but with those of tubercular laryngitis very prominent, the lungs were found greatly diseased. Some of those who examined the patients pronounced against the existence of tubercle in the lungs, and yet they were found full of tubercles. No one could be certain of the absence of tubercle of the lungs till he had made a *post mortem* examination.

Dr. Bowlby, of Berlin, said that he had a case under his care at present, that he believed was exactly similar to the case reported by Dr.

Palmer, but he did not know how he could satisfy gentlemen holding opinions such as those expressed by the last speaker, except an ante-mortem examination could be held in each case.

Dr. Sloan regretted that the writer of the paper had not alluded to the means of diagnosis furnished by the thermometer. He believed that in every case during the deposition of tubercle, there was a continuous and persistent rise of temperature of one to two degrees. The great value of this appeared in doubtful cases, where the thermometer furnished almost absolute proof of the correctness of the diagnosis arrived at by the physical signs brought before them.

Dr. Hamilton, Port Hope, said that the case reported was one of the rapid cases. Tubercular phthisis may run its course in three months or may last as long as four years. It could be best studied in the slow cases. He had just had a fatal case of three years' duration, in which, with a consumptive family history, there were decided laryngeal symptoms six months before there was any cough at all. There was aphonia for a year, and for some weeks extreme difficulty in swallowing, owing to ulcerative destruction of the epiglottis. He was quite prepared to accede that the disease might be manifested primarily in the larynx, so far as symptoms could be gathered *ante-mortem*. Tuberculosis is a constitutional disease, however. If we find an ulcer of the larynx, we should suspect its tubercular character if we find marked cushiony swelling in the neighborhood of the arytaenoid cartilages conjoined with a paleness of the laryngeal mucous membrane which could best be described as a dirty doughy white. Syphilitic ulcers, malignant ulcers, and catarrhal ulcers, being rationally excluded and our suspicions aroused, the only early lung symptoms worth relying on were increased vocal resonance and increased vocal fremitus in the apices of the lungs. This was caused by consolidation which may not yet have caused bronchitis and necessary cough, and could not be as certainly known by percussion and other auscultatory signs. Twenty years ago we were taught that the vast majority of phthisical lung lesions

began in the apex. This was true in neither the pneumonic or catarrhal variety, nor in fibrous phthisis; but it was true in the tubercular, and almost invariably so in the laryngeal phthisis. He had in consultation given a most unfavorable prognosis in a case without any but the most trifling cough, and which proved fatal—relying upon the signs indicated. Progressive and considerable emaciation was significant. Vocal resonance and fremitus were normally greater on the right side. If the increase were on the left side it was an especially significant symptom.

### THREE CASES OF EXOPHTHALMIC GOITRE TREATED BY ERGOT.

BY J. STEWART, M.D., L.R.C.S. AND P., ED.

Read before the Canada Medical Association at Halifax.

**CASE I.**—Miss W., aged 35, when seen for the first time in June, 1875, complained of a severe pain in each eye-ball, with dimness of vision. She also complained of palpitation of the heart, and enlargement of her neck.

*Past History.*—She says she enjoyed excellent health up to her first menstrual period, which took place when she was only 11 years of age. She lost a great quantity of blood at this time. From her twelfth to fourteenth year the catamenia were irregular—sometimes once a month, sometimes once in four or five months. From this time up till the present she has menstruated very regularly every six weeks. She has been troubled with palpitation of the heart for eight years. Seven years ago she had pneumonia, followed by acute rheumatism. The latter assumed an intermittent character.

*Family History.*—Her father died at 60, from typhoid fever; mother at 45 from paraplegia, due, it was said, to softening of the cord. She lost a brother from dysentery, one from cerebro-spinal meningitis, a third from consumption, and a fourth was accidentally killed. Her only sister died from consumption. She is the sole survivor of a large family.

The history of the present attack dates from the month of October, 1874, when she began to be wakeful and nervous at night. After these symptoms had lasted for six weeks her

eyes were noticed by a friend to be more prominent than usual. At this time her eyes were very painful. The pain was deep-seated, and extended back to the occiput. Her neck was enlarged and she had a constant inclination to swallow. Shortly after the appearance of the latter symptom she says the neck increased rapidly in size, and she was troubled very much with throbbing in it.

*State when first seen* (June, 1875). There is a very marked prominence of both eyeballs, and abrasion of the cornea—this latter evidently due to the inability of the lids to cover the corneae. There is marked enlargement of the thyroid body, especially of its right lobe. The pulse is said never to be below 120, and on the least exertion it beats as high as 150 or 160. A systolic murmur, loudest over the base of the heart, is heard. Belladonna was given to her at this time for about two months, and it seems to have had some effect in diminishing the exophthalmos, with but little or no effect on the other symptoms. During a visit to United States she stopped the belladonna and took strychnine, and in such doses as to cause severe symptoms of poisoning. She was not benefitted in the least by the strychnine, and on her return to Canada I put her under ergot, commencing with ten m. doses of the fluid extract three times a day. She was not taking this long before it was apparent that there was quite a diminution in size of the thyroid and less protuberance of the eyeball; but it was on the pulse that the beneficial effect was first seen. From a pulse constantly at about 140 it was reduced in a few weeks to about 100 to 110. This improvement continued steadily until the pulse came down to between 80 and 90. Simultaneously the eyeballs lost their prominence, and the thyroid underwent great diminution in size. She continued taking the ergot for a year, the dose of which was increased to fifteen m. three times a day during the last three months of this period. At the present time (July, 1881,) she is perfectly free from all symptoms of her troublesome affection.

**CASE II.**—Mrs. M., aged 32, married, two children, youngest aged 18 months. When first seen, in June, 1880, she presented all the characteristic symptoms of exophthalmic goitre



in a pronounced degree, including the want of consentaneous movements between the eyelids and eyeballs.

Her family and previous history are unexceptionable. It was four years ago that she felt the symptoms of her present trouble in the shape of nervousness, weakness, and palpitation of the heart. For six weeks previous to the appearance of these symptoms she was much worried mentally, and over-worked physically in nursing a child who had been ill with bronchitis and catarrhal pneumonia. It was soon afterwards noticed that her eyeballs were more prominent than they naturally were. Her husband "wondered why she stared so at him." About the same time appeared enlargement of the neck, principally on the right side. She continued in this state, now better, and now worse until I saw her in June of last year. Her pulse was constantly found to be 120, and on the least exertion it ran up to 150 and over, and she complained of great palpitation of the heart. She had been taking iron and digitalis for months, but without the least sign of improvement. She was ordered fifteen m. doses of the fluid extract of ergot (Saunders') three times daily. She had not been long under this treatment when it was found that the pulse was reduced to 100, and there was less palpitation of the heart. She could undergo exertion better, and expressed herself as feeling much improved. The next symptom found improved was the motions of the eyelids, which now followed the eyeballs, but still tardily. Then came reaction of the eyeballs and later diminution in the size of the thyroid body. She continued taking the ergot until three months ago, when she expressed herself as feeling so well that she thought it was unnecessary for her to continue the treatment any longer. On examination at this time the pulse was 80, there was no exophthalmos and the thyroid was normal in size. At the present time she is in excellent health, and no symptoms of her former trouble are to be detected.

CASE III.—Mrs. S, aged 29, married, five children, youngest aged five. Consulted me in January of the present year, complaining of weakness, violent palpitation of the heart, and cedema of the lower extremities. Family and

previous history good. Six months previously the first symptoms of her present trouble showed themselves. She commenced to feel weak, and her heart beat violently on the least exertion. The eyeballs became protuberant and she complained of having much pain in them. The thyroid enlarged very rapidly. When first seen the enlargement was very extensive, and she was greatly annoyed from "an almost constant beating in her neck and noises in her ears." She expressed herself as unable to go upstairs, on account of the violent palpitation and a sense of suffocation. The exophthalmos was extreme enough to prevent the lids from protecting the corneæ, and the latter, in consequence, were found abraded. Von Graefe's symptom was well marked. The pulse was found to be 140 and irregular. A loud systolic murmur, having its maximum intensity in the cardiac region, was heard. The lower extremities were cedematous. She commenced taking fifteen minim doses of the fluid extract of ergot three times daily, but in a few days this treatment was interrupted by a severe attack of pneumonia, from which however she made a good recovery. She has been taking the ergot now for about five months, and is still continuing it. She was examined on the 22nd of July, and it was found that she had much improved. The exophthalmos and goitre are both much less. She is not troubled now with pain in the eyeballs, beating in the neck or noises in the ears. Her pulse is 88, and active exercise has not any more influence in increasing it than it has in the normal state. The cedema of the lower extremities has disappeared, but the mitral murmur still persists. She says that she feels well, and does not consider herself an invalid. When this patient first came under observation an unfavorable prognosis was given, on account of the severity of the symptoms, and the complication with what then appeared to be an organic disease of the heart, but judging from the late intermittent character of the murmur is likely functional. The pulse is still irregular and presents evidence of high tension.

A fourth case of exophthalmic goitre has come under my observation, but as its onset was so sudden and its duration so short, I con-

sider that the ergot which was given had but little to do with the result. It occurred in a girl, aged 18, who received a very violent shock in witnessing the sudden death of her brother, who was considered to be at the time convalescent from a mild attack of diphtheria. The disease made its appearance in this case in one night, and when seen the following day she presented a good example of a typical exophthalmic goitre. In about ten days all the symptoms had disappeared.

CAUSSIDOU ON THE TREATMENT OF TYPHOID FEVER BY SALICYLATE OF SODA.—M. Caussidou made a communication to the meeting of the French Association for the Advancement of Science at the Congress of Algiers, which was based on thirty-two cases of typhoid fever treated by salicylate of soda, and in which the rise of the temperature and the influence of this drug on the febrile process has been registered with the greatest care, as attested by numerous tracings shown by the writer. M. Caussidou arrived at the conclusion, in opposition to the facts observed in several wards of the Paris hospitals, that salicylated medication gives larger, more certain, and more permanent effects than refrigeration. M. Caussidou has even been in doubt if, by administering salicylate of soda from the outset of typhoid fever, it would not be possible to limit the duration of the disease to the first week (?), and if, at least, it would not be possible to obtain a number of cases belonging to the abortive form. Nevertheless, M. Caussidou does not conceal the dangers of salicylate medication. Like other observers, he has noted dyspnoea, precordial trouble, and exhaustion in patients where the salicylate of soda have brought on a too sudden apyrexia. To avoid these objectionable results, he proposes to administer salicylate of soda in fractional doses of one gramme given every two hours, and to stop as soon as the temperature falls below 38 Cent. (100.4 Fahr.). In a complicated case of erysipelas, the salicylic medication was powerless to produce a febrile recrudescence brought on by this complication. M. Hérard declared that he had nothing but commendation for the use of antiseptics, such as carbolic and salicylate acids, in the treatment of febrile diseases.—*London Medical Record.*

## Selections: Medicine.

### WASHING OUT OF THE STOMACH.

M. BUCQUOY and M. Constantin Paul have recently published some interesting details on this subject, which are analysed in the *Journal de Médecine et Pratique*. M. Bucquoy, who was one of the first promoters in France of this method, borrowed from Kussmaul, relates a new case concerning a man suffering from a considerable dilatation of the stomach, consecutive on a stricture of the pylorus itself, which supervened after the injection of nitric acid. He was dying literally from hunger, in consequence of complete gastric intolerance, when he was submitted to washing out of the stomach with Faucher's tube; a considerable improvement was then quickly produced, and the patient increased in weight more than two kilogrammes in a fortnight; however, he was attacked by new troubles, and succumbed to pulmonary phthisis shortly afterwards. M. Bucquoy enlarged greatly on the various indications which might be met by washing out the stomach.

M. Constantin Paul has especially studied this question at great length, and has published some very useful hints on the method of employing the operative proceeding. It must first be noted that, for the operation in question, the sitting position of the patient is most favourable; certain timorous and nervous persons, however, should be put in the reclining position for the first few times. The instrument used is Faucher's tube, with this restriction, however, that it may be useful during the first few days to use the ordinary stiff sound to overcome the œsophageal spasm which sometimes occurs at this moment, but which disappears after a few applications. In order to remedy this inconvenience, M. Debove has had a screw constructed which much facilitates, in this case, the introduction of a flexible India-rubber tube. When, however, the patient himself introduces his sound, which he always does very rapidly, a stiff tube is, on the contrary, a necessary condition, since it enters by a true swallowing movement. M. Audhoui has had constructed a flexible tube



with a double stream, which much facilitates the washing out of the stomach, but in which the tube whence the liquids issue is, as a matter of necessity, restricted, which is a serious inconvenience. The method of introduction, as described by M. Bucquoy, is as follows. The tube being slightly moistened with water (M. C. Paul recommends that it should be greased with vaseline during the first few days only), the patient takes the free end of the tube, places it in the pharynx, and pushes it slightly, making a swallowing movement. He repeats this swallowing movement a certain number of times, guiding the tube with the hand; this penetrates into the stomach rather rapidly; and the patient stops when he sees near his lips a mark traced at from forty-five to fifty centimetres from the free end then lying along the large curve of the stomach. To charge the siphon, the patient pours alkaline water into the receiver; and, after having filled it, raises it above his head until the liquid has entered almost entirely. At this moment he lowers the receiver below the level of the stomach, and above the basin. The cylinder becomes filled immediately with the contents of the stomach; and it will be seen that there returns a more considerable quantity of liquid than has been introduced, bringing with it the residue of digestion.

The operation is repeated a certain number of times, and as often as necessary, until the water returns in an almost limpid state. Alkaline water is generally employed for these operations. M. Constantin Paul has found that the silicated water of Sail, or an antiseptic solution containing thymol or hyposulphite of soda, is useful. To conclude the operation, he pours into the stomach two or three hundred grammes of milk. The first liquids injected are tepid, because they cleanse the parts better; the later ones are cold, because they form a better coating for the mucous membrane, and induce contraction more easily. In certain serious cases, the operation is renewed twice daily; in ordinary cases, once only at the beginning, then less frequently afterwards. Whatever may be the nature of the gastric affection thus treated, according to M. Paul, good results are almost immediately

obtained; in the first place, cessation of the pain; then the appearance, at the end of some days, of spontaneous action (in the case of dilatation); finally, a reappearance of the appetite, and a much more rapid augmentation of weight than would be believed. At the present time, washing out of the stomach is no longer limited to dilatation, as it was at first. It is applied to various affections. M. Paul quotes cases of gastralgia, of hysterical vomiting, of gastric ulcer, which have been thus completely cured. He has thus been able to greatly relieve the sufferings of a woman who had fæcal vomiting, and who suffered from an umbilical hernia; finally, in cancer of the stomach, the symptoms are very much relieved, and it is possible even to bring on a notable temporary improvement. MM. Bucquoy and Ferrand have also observed cases of cure of simple ulcer. M. Debove likewise has reported, in the *Progrès Médical*, an extremely remarkable case of cure of a patient suffering from a simple ulcer, probably very old in origin, with absolute intolerance of the stomach, and a state of extreme cachexia. The favourable results obtained were almost immediate; and, at the end of six weeks, the patient, who had increased from one hundred to one hundred and twenty-five grammes daily, was on the road to complete recovery.

Professor Germain Sée, in his treatise on gastro-intestinal dyspepsia, relates a certain number of cases which well demonstrate the utility of this method in gastric affections of very different kinds. He speaks of the case of a young girl suffering from serious anorexia, with invincible refusal of all nourishment, who had reached the last stage of marasmus, and who was treated for six months with this mechanical treatment. Dr. Sée has also seen obstinate vomiting thus stopped; cancer is greatly relieved, and dyspepsia of the cachectic form, which seemed of the nature of cancer, has been completely cured. In the last case, as well as being a means of treatment, it forms a true method of diagnosis. This brief enumeration shows the great importance of this new mode of treatment, which unites perfect harmlessness to very great facility of employment, since, up to the present time, not a single accident has been known to occur from the operation.—*British Medical Journal*.

## NOTHNAGEL ON THE CLINICAL ASPECTS OF INTESTINAL DISEASES.

To determine whether conclusions can be drawn from the condition of the fæces as to the nature of the pathological process in the bowels, and as to the seat of the disease, whether in the rectum, colon, or small intestine, is the object of an extremely able article by Professor Nothnagel (*Zeitsch für Klin. Med.*, vol. iii, p. 241, 1881.) He concerns himself almost exclusively with the macroscopic and microscopic examination of the fæces, since this method of investigation is of much greater practical importance to the physician, and much more readily carried out, than chemical analysis. This article embodies the results of the examination of more than 800 fæces. In many cases the examination was conducted daily until death, and most people will agree with Nothnagel, when he remarks that such investigations are not amongst the most delightful. In regard to consistence, he divides fæces into three classes—the firm, the pap-like (*breiig.*) and fluid, the first of which are generally normal, the others pathological. The most important clinically is the variety of pap-like consistency, which is occasioned by a very intimate mixture of mucus. Often the naked eye detects nothing resembling mucus, but microscopically its presence is readily made out. Such consistency may be occasioned by admixture of fat, water, parenchymatous tissue of vegetables, and fruit, etc. Fluid fæces can never, according to Nothnagel, be occasioned by the consumption of large quantities of water. In five cases of diabetes insipidus which he had recently watched, there was nothing of this kind. Hard fæces in small balls, like the fæces of sheep, are not, according to Nothnagel, at all a certain indication of obstruction. With regard to reaction, there is considerable variety, fæces being acid, neutral, or alkaline at different times. In typhoid fever they are as a rule alkaline (though, exceptionally, Nothnagel has found a strong acid reaction); and in a doubtful case, if the reaction were not alkaline, it would go against the diagnosis of typhoid. The colour of the fæces may be affected by various articles of diet and medicine; the only impor-

tant point is the reaction of bile-pigment, which may be frequently met with. Crystals of triple phosphate may be found in any stool, and they are not met with in typhus dejections in greater quantity than normal. Salts of lime (including oxalates) occur also in the fæces, but they appear to be of no diagnostic value. Cholesterine is a component of normal fæces, and does not possess any significance. "Charcot's crystals" are also to be found. Of the various articles of diet that appear in the fæces, Nothnagel only touches upon such as are of particular diagnostic importance. *Starch.* In the normal condition, with an ordinary mixed diet, starch-granules do not appear in the stools, but small, irregular particles, which colour blue with iodine, occasionally do occur. Any deviation from this is pathological. Muscular fibre is to be found in small quantity in normal fæces with mixed diet, but occurs to a great extent when much animal food is taken (diabetes); and it is particularly interesting to observe that in many intestinal diseases muscular fibre is to be found in large quantity in the stools, even in cases where starch does not appear, showing how much more readily the latter undergoes digestion than the former. Fat occurs in normal fæces, both in drops and in needles. Sometimes Nothnagel has found it in large quantity without any pancreatic disease. Milk, in the form of coagulated flakes, showing countless enclosed oil-globules, is often seen in normal fæces. Such are the more important articles of food which occur in the stools. Regarding mucus, many important diagnostic indications may be derived from its presence in the fæces, in what form it appears, whether it is coloured or colourless, and in what way it is mixed up with the fæcal matter. In the adult, no mucus is to be found either macroscopically or microscopically in normal fæces. Its occurrence is always pathological, and it may appear either (*a*) as a thin layer over well-formed fæces, or (*b*) intimately mixed up with the fæcal matter, or (*c*) the fæces may consist entirely of mucus, (*d*) as mucus cylinders in the so-called tubular diarrhoea, (*e*) in balls resembling boiled sago-grains. The latter form Virchow has considered as of vegetable origin. And, finally,



Nothnagel describes a new appearance (*r*) in which the mucus takes the form of round yellow balls, quite unlike sago. The epithelium which frequently occurs in the sputum undergoes certain changes in shape, which Nothnagel describes with great minuteness, and for which the original article must be consulted. The 'round cells' which occur in the fæces have some diagnostic significance. They vary in size from that of small, white blood-corpuscles up to that of the largest giant-cell. In simple catarrh of the intestine, mucus, containing round cells, does not occur. Its presence in the fæces indicates an ulcerative process. Nothnagel states nothing new regarding the presence of blood in the fæces; and to the presence of animal parasites, their eggs, etc., in the fæces, we need not here allude. Nothnagel proposes, in a continuation of this article, to consider the clinical bearing of the appearances here touched upon. — *London Medical Record*.

#### EXAMINATION OF SPUTA.

In suspected cases of phthisis where it is very desirable to know the progress made by the disease, great aid may be procured many times by an examination of the sputa of the patient. It is now a recognized fact that phthisis has been diagnosed, and is diagnosed in this way, weeks, months before other signs are manifest.

As expected ingredients in the sputa, one finds remains of food, starch granules, epithelium, air bubbles, mucous cells, pus cells, blood corpuscles, large granular cells, and, perhaps, pigment cells. If now besides these are found fragments of lung tissue, as yellow elastic fibres, it shows that there must be a disintegration of the pulmonary tissue, a condition which must denote serious trouble. If these fibres are not found it does not by any means prove that serious trouble may not exist, but their presence is very significant.

Some special directions should be given to the patient whose sputa we are about to collect. First, the mouth should be carefully and thoroughly rinsed and the teeth brushed after each meal. Second, the vessel in which the

sputa is collected should be scrupulously clean. Third, if the patient is in the habit of using tobacco, it should be denied during the collection of the sputa, as the fibres of the leaf might mislead and cause a wrong diagnosis. If the amount of sputa is small, then all raised during the twenty-four hours should be saved. If large, that first raised in the morning should be preferred.

Any little grayish masses should be chosen and placed at once under a microscope. Acetic acid will clear up the mucus, etc., and render more distinct the yellow fibres if they are present. If this examination reveals nothing, the following method should be adopted:

Make a solution of sodic hydrate, 20 grains to the ounce of water. Mix the sputa with an equal bulk of this solution and boil. Then add to this mixture 4 or 5 times its bulk of cold water. If possible, pour into a conical-shaped glass and set aside. Soon the yellow fibres, if present, will fall to the bottom; from where they can be drawn up with a pipette and examined. Several glass slides should be examined at a single sitting, and the examination should be repeated every few days until the presence or absence of these fibers is satisfactorily demonstrated. — *Cincinnati Medical News*.

APHONIA THE RESULT OF DIVISION OF THE RIGHT RECURRENT NERVE BY A STAB WOUND.—Dr. Lefferts reports, in July number of *The American Journal of Medical Science*, the following remarkable case. A healthy woman æt. 47, while lying in bed on her left side, was stabbed in the right side of the neck by her drunken husband with a long narrow-bladed pair of shears. Complete aphonia followed and remained persistent, although the wounds (two) healed normally. The patient is able to speak only in a whisper, and suffers from slight dyspnoea, especially on exertion. A laryngoscopic examination shows absolute paralysis of all the muscles of the right vocal cord. The left vocal cord moves freely and compensates for the defective action of its fellow, by passing the median line on adduction, its arytenoid cartilage passing in front of that of the paralysed cord, and thus fairly approximating the edges of the cords.

# CASEOUS ACCUMULATIONS IN THE MIDDLE EAR REGARDED AS A PROBABLE CASE OF MILIARY TUBERCLE.

BY THOMAS BARR, M.D., GLASGOW.

In this paper, attention was first drawn to what was said on the subject by such writers as von Tröltsch. An account was given of recent views on the pathology of miliary tuberculosis, as expressed by Buhl and Cohnheim, as well as by eminent British pathologists. There was a general agreement that acute tuberculosis depended on a virus, and that this virus often consists of caseated products of inflammation accumulated in some part of the body. An anatomical description of the cavities of the middle ear was given, the frequency of exudative diseases in these parts was pointed out, and the character of the exudations was noted. The peculiar structure of the middle ear was dwelt upon, because it favoured the retention, drying, and ultimate caseation, of the catarrhal products formed therein. Reference was next made to the facilities for the absorption of the caseated matter afforded by the blood-vessels of the middle ear, and by the lymphatics; absorption by the former leading to general tuberculosis, and absorption of the latter leading to local tuberculosis, and especially to tubercular meningitis. There was special danger of tubercular self-infection when such caseous collections existed in persons of scrofulous tendencies or at the tubercular age. There was a stage in the purulent process when there was greater danger of pyæmic phenomena; but there was also a stage when the tendency to tubercular self-infection was greatest, and that was after the discharge from the ear had spontaneously ceased or had been cured by treatment. Unfortunately, there was a paucity of material derived from observation, on account of the middle ear being usually ignored in *post-mortem* inspections and in clinical examinations. By a simple and expeditious plan, the middle ear in the cadaver might be examined by the pathologist. It was urged, in conclusion, that in the case of tubercular disease, and especially of meningitis, attention should be given to the condition of the middle ear.—*The British Medical Journal*,

## WICKHAM LEGG ON BILE.

"To what purpose, then, serves the bile?" asks the author in p. 155, and his reply is worth quoting. "It cannot be looked upon solely as an excrement, for it has been seen what deep changes in nutrition follow its diversion from the body. There is no evidence that it is necessary for the completion of the process of digestion in the stomach or intestines; indeed it may be said by some physiologists that it does harm to the process in either viscus. The view that it acts as a sort of natural purge has little against it; but at the same time, there is but little in its favour. As to the power of the bile in arresting putrefaction, it would seem that it must be small, if, as soon as it arrives in the intestine, it begins itself to undergo putrefactive changes. The view that the bile neutralises the acid of the chyme must fall with the establishment of the fact that the bile is not alkaline, but neutral in reaction. The only office which remains to it is that of emulsifying fats, a property known to the Greeks 2,200 years ago, and of changing starch into sugar. \* \* \* \*

Enonymin and iridin are shown to be (as most practitioners now know,) active cholagogues. Dr. Legg points out that the want of colour of *feces* is not necessarily due to a decrease in the secretion of bile, as it may be due to the absorption of bile after it has passed into the intestine. Chemical analysis is, in his opinion, the only trustworthy guide in judging of the presence or absence of bile in the *feces*.—*Birmingham Med. Review*.

PEPSINE AS A SOLVENT IN ALBUMINOUS OBSTRUCTION OF THE BLADDER.—Dr. Hollmann (*Nederl. Weekbl.*, 18, p. 272) reports the case of an old man, aged 80, suffering from retention of urine, in whom the introduction of a catheter failed to procure the desired result. It was found that the bladder contained coagulated albuminoid masses, mixed with blood. A few hours after the injection of about sixteen grains of pepsine dissolved in water, a large amount of a dark, viscid, fetid fluid readily escaped by the catheter.—*London Medical Record, Medical News and Abstract*.



## THE ACTION AND USES OF ANTI-PYRETIC MEDICINES.

BY PROFESSOR FOKKER, GRONINGEN.

While there is no great difficulty in understanding the mode of action of simple refrigeration in the treatment of pyrexia, that of antipyretic remedies, administered internally, is still obscure. We must assume, either that they lower the temperature of the body by interfering with the circulation, or that they exert a destructive action, in virtue of their antiseptic properties, on the low organisms to which the pyrexial phenomena are presumably due. The second of these hypotheses is the more likely one. It may, of course, be objected that such remedies can never be administered in sufficient quantities to insure their presence in the blood in such proportions as to render it aseptic, or, at any rate, to exercise an antiseptic influence. It must not be forgotten that any hostile factor, though unable of itself to check the multiplication of the organisms, may succeed in doing so when combined with others equally hostile to bacterial life. It is quite possible, moreover, that antipyretic medicines may accumulate in particular organs, which may then exert a disinfectant influence upon the blood. Antipyretic remedies may legitimately be given in febrile maladies, when the heat of the body is such as to threaten the patient's life, or even the integrity of his tissues. Under such circumstances, those aromatic remedies which are, at the same time, bacterial poisons, should be preferred to physical methods of refrigeration. But when the temperature of the body does not rise to a dangerous height, the employment of such remedies in antipyretic doses is undesirable; since a degree of heat only a little above the normal temperature of the body is injurious to the vitality or the virulence of the pathogenic organisms. It is quite possible, indeed, that the febrile heat may be one way in which the system reacts against the organisms, and tends towards recovery. In all cases, therefore, when the temperature does not rise so high as to be of itself a source of danger, physical refrigeration should be avoided, and the antipyretic remedies should only be prescribed in relatively small doses.—*The British Medical Journal*.

## THE CLINICAL VALUE OF THE EXAMINATION OF THE URINE IN BRIGHT'S DISEASE.

BY T. GRAINGER STEWART, M.D., EDINBURGH.

The subject was discussed under the following head: (a) Quantity: Diminished: 1, in inflammation (early stage and during exacerbations). Normal: 1, in middle stage of inflammation; 2, in earlier stages of cirrhosis. Increased: 1, in waxy throughout (unless interfered with) and preceding even the albuminuria; in cirrhosis—later stage; 3, sometimes in advanced inflammation and during absorption of dropsies. Suppressed: In inflammation acute and advanced cirrhosis: (b) Specific gravity and solids. Influenced: 1, by amount of water; 2, by amount of urea; 3, by amount of other solids; urea in different forms. (c) Albumen, serum-albumen, the only very important form; quantity in different forms; explanations. (d) Blood. [1, Early inflammation and acute exacerbation; 2, very rarely in waxy kidney; 3, occasionally in late cirrhosis with other hæmorrhages. (e) Tube-casts; varieties; different views as to the origin; abundant and varied in inflammation; few in waxy kidney; few in cirrhotic kidney.

## ON DIFFERENT FORMS OF BRIGHT'S DISEASE.

BY DR ROSENSTEIN, LEYDEN.

The following is a summary of the paper:—  
1. the anatomical basis of the disease described by Bright is the diffuse inflammation of the kidneys. 2. Consequently those demonstrable renal changes, which are not of an inflammatory character—e.g., “the kidney of pregnancy,” the “cyanotic induration” observed in conditions of venous obstruction of the system, and the “pure amyloid degeneration,” do not represent, though associated with anasarca and albuminuria, forms of Bright's disease, but are independent affections, strictly to be differentiated from this disease. 3. Different forms of Bright's disease are to be distinguished anatomically as well as clinically, according to the “acute” or “chronic” course of the inflammatory process. 4. The acute form is characterized by the emigration of colourless blood-

corpuscles (as in inflammations of other organs), and by changes of the epithelial structures, to which, after a short duration, a proliferation of the nuclei of the interstitial tissue is added. This form ends most frequently in recovery, and passes but extremely rarely into the chronic form. 5. The chronic form shows anatomical changes of all the tissue-elements of the kidneys. According to the preponderance of alterations in one or other of these elements, the product appears in the different conditions of the "large white," or the "variegated smooth contracted kidneys," or the "granular white kidney." 6. The clinical observation of some exceptionally suitable cases renders it highly probable that the "white granular kidney" is developed from the "large white kidney," and is consequently to be looked upon as a further stage of the same process. 7. A particular form of "granular kidney" is represented by the "red granular kidney," in so far as this form does not start from a diffuse inflammation, but from "endarteric changes" of the renal vessels, with shrinking of the glomeruli. Closely related to this form in its genesis is the "senile contracted kidney," which is, therefore, to be associated with it. 8. As to the starting-point of the anatomical changes, no evidence is offered by clinical observation. The latter should, therefore, be limited to the recognition, in general, of the state of the diseased organ—*i.e.*, to recognize whether this is in the state of "enlargement," or of "contraction;" but it ought not to speak of "parenchymatous" or "interstitial" forms, as it does not possess any means of distinguishing between these.—*British Medical Journal*.

### CHRONIC BRIGHT'S DISEASE WITHOUT ALBUMINURIA.

BY F. A. MAHOMED, M.D., (London.)

The main object of the paper was to prove that high arterial pressure, in young and apparently healthy persons, if it remain as a chronic condition, will produce the cardio-vascular changes of Bright's disease. It was held that the changes found in red granular kidneys are chiefly vascular in their nature; *i.e.*, thickened vessels, thickened Malpighian

capsules, and fibro-hyaline intertubular thickenings; the yellow, or mixed granular kidneys, have, in addition to these, interstitial small celled growth and epithelial proliferation. Chronic Bright's disease was described as existing typically in three stages: 1. The functional stage, *i.e.*, high arterial pressure without organic change; 2. Chronic Bright's disease without albuminuria (or nephritis), *i.e.*, the cardio-vascular changes, usually with red granular kidney; 3. Chronic Bright's disease with albuminuria, or urine of low specific gravity, *i.e.*, the cardio-vascular changes with the mixed or yellow granular kidney. The present paper was to prove the existence of the second stage without albuminuria. It was founded upon sixty-one cases, in nearly all of which the urine was ascertained to be perfectly normal in quantity, specific gravity, and the absence of albumen, the latter being only occasionally present just before death. Nearly all these cases were diagnosed during life by hypertrophy of the heart and high arterial pressure. Of these, twenty-one cases were fatal, and an account of the *post-mortem* examination of each was given; in all the others, the signs were unmistakable, there being in all displacement of the apex external to the nipple-line, and high arterial pressure; in many, evident thickening of the arteries, and other occasional signs. The cases were grouped as follows: cardiac failure, ten cases with eight deaths; lung-failure, eleven cases, six deaths; cerebral disease, nine cases, two deaths; renal dropsy, nine cases, one death; gout, six cases; epis-taxis, three cases; various medical and surgical diseases, nine cases, four deaths. There were also four cases with well marked albuminuria, disappearing temporarily or permanently. The twenty-one fatal cases included five in which there was hypertrophy of the heart without valvular disease; in all, the vessels were thick, but there was little or no renal change.—*British Medical Journal*.

Prof. Otto Spiegelberg, of Breslau, the famous Obstetrician, and the founder, in conjunction with Cr  d  , of the *Archiv. f  r Gyn  cologie*, is dead.



## GOWERS ON PARALYTIC CHOREA.

Five cases in children of ages varying from 7 to 14 years, three of whom were girls, formed the basis of a paper read by Dr. Gowers at last year's meeting of the British Medical Association. They illustrate that form of chorea in which the muscular weakness is the prominent symptom, the twitching, and inco-ordination of voluntary movement being slight. In regard to such cases, Dr. Gowers remarks, rarely slight clonic spasm occurs in the affected arm at first, and subsequently passes off. The loss of power may be very great, as it may be much less than the loss of use of the limb would suggest. In these cases there is inaction rather than paralysis; usually one arm only is affected, and there is no paralysis of face, tongue, or leg. Both arms may be affected, but one is always the weaker. On careful watching, clonic twitching is to be observed, though often very slight. The course of such cases is very tedious, but they have not been seen to pass into severe general chorea. The reported cases all recovered under the use of liq. strychniæ.—*London Medical Record*.

## EAR AFFECTIONS IN CHILDHOOD FROM DENTITION OR A CARIOUS TOOTH.\*

"A considerable portion of the blood supply of the membrane of the drum is derived from an artery that leaves the internal carotid in the carotid canal and proceeds by a very short course directly to its destination. Being thus closely connected with a large arterial trunk, this small tympanal branch of the internal carotid possesses very favourable circumstances for a speedy augmentation of its blood supply. The nervi vasorum constituting the carotid plexus at this part of its course come largely from the otic ganglion. On the other hand the inferior dental nerve supplying the decayed tooth, or the gums, as the case may be, also communicates with this ganglion. We thus arrive at a direct channel of nerve communication between the source of irritation of the tooth, and the vascular supply of the drum head."

\*"From Deafness, Giddiness, and Noises in the Head." By Edward Woakes, M.D.

## ON INFLUENCE OF HYDROCHLORATE OF QUININE ON MALARIAL GERMS.

BY DR. CECI, CERINO.

Dr. Ceci gave an account of experimental researches, made in the laboratory of Professor Klebs, of Prague, on the influence exerted by quinine-hydrochlorate on the development of germs contained in malarial soils. A cultivation-liquid of a 5 per cent. solution of isinglass was employed, infected from different sources, and in every case it was found that the presence of very minute proportions of this salt exercised a remarkable power in preventing or checking the development of the *schizomycetes*. One part in 800 was sufficient to prevent any development of germs. The *bacilli malarie* made their appearance very seldom in the cultivation-liquids, even when the proportion of quinine was very insignificant.—*The British Medical Journal*.

MR. J. N. DAVIDSON, Manufacturing Pharmaceutical Chemist, Dundee, has an interesting collection of preparations, one of the most important being a Compound Cod-liver Oil Emulsion, which is also shown in another form, in which quinine is added; and in a third formula, called Compound Phosphorised Cod-liver Oil Emulsion; and in a fourth, in which quinine is present as well as phosphorus, the quantities being, in addition to the oil, one-fifteenth of free phosphorus in each ounce, and one grain sulphate of quinine per ounce. In each case the emulsion is perfect and permanent, and does not separate. Mr. Davidson has succeeded in medicating this popular oil, so as to make it tasteless and scentless; and he makes no secret of his process. He turns the oil into paste by mixing 75 per cent. of it to 25 per cent. of pepsine, hypophosphite of lime, and lactophosphate of lime. The result is a paste that may be eaten like butter, and of most unobjectionable character. A host of the profession in North Britain speak in the highest terms of Mr. Davidson's formula.

THE cough of consumption is treated by M. Rinde, by iodoform. He gives from one-fourth to one-half a grain four or five times daily.

ON THE DIAGNOSIS OF THAT FORM OF ACUTE RENAL DISEASE WHICH IS DESCRIBED BY KLEBS UNDER THE NAME OF GLOMERULO-NEPHRITIS.

BY GEORGE JOHNSON, M.D., F.R.S. (London.)

For a number of years Dr. Johnson described and demonstrated, under the name of exudation cell-casts or white cell-casts, a form of renal tube-cast characterized by the presence of leucocytes unmixed with renal epithelium; and in his lectures on Bright's Disease (page 35) he stated that "since the publication of Cohnheim's researches, it had occurred to him that these exudation-cells may probably be white blood-cells—leucocytes—which have migrated through the walls of the Malpighian capillaries, and subsequently become moulded into small cylindrical casts within the central canal of the convoluted tubes." The object of the present communication was to direct attention to the relationship between the anatomical observations of Klebs (*Handbuch der Path. Anat.*, vol. i., p. 644), Klein (*Path. Trans.*, 1877), and Bryan Waller (*Journal of Anat. and Phys.*, 1880.) and his own clinical observations, and to show that the presence of the white cell tube-casts afforded the means of diagnosing the existence of the glomerulonephritis of Klebs.—*British Medical Journal*.

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FERNET'S METHOD OF INTRODUCING FOOD AND MEDICINE BY THE NOSTRILS.—M. Fernet (*Revue de Thérap.*) wishes to popularize the method of introducing liquid or semi-solid elements, and certain drugs, by the nostrils. The author has seen it employed successfully in newly-born infants, too weak to take the breast or milk from a spoon. He proceeds as follows. The patient being laid on his back, a little raised, the end of a spoon, or, better, the spout of a close vessel, is brought near to one nostril, and its contents are poured in gently at intervals. The liquid slides over the floor of the nasal fossa and the roof of the palate, and reaches the pharynx, where it induces movements of regular deglutition. If the operation be done well, the liquid never returns by the other nostril. This method may be applied in certain cases of apoplectic coma, when the patient cannot drink for three or four days successively, in the tuberculous meningitis of children, etc.

COGHILL ON ANTISEPTIC INHALATIONS IN PULMONARY AFFECTIONS.—Dr. J. G. Sinclair Coghill, in the *British Medical Journal*, May, 1881, p. 841, has an interesting paper upon the value of antiseptic inhalations in all lung affections characterized by purulent expectoration. By this means we are enabled to dispense with cough-mixtures by arresting the secretion of the sputa; for, if sputa exist, cough must necessarily follow, and it is dangerous to arrest the cough under such circumstances. Dr. G. Coghill finds the following formula good: R Tincturæ iodi etherealis, acid carbolicæ, aa ʒij; creasoti vel thymoli, ʒj; spiritûs vini rect., ad ʒj; M. If the cough be urgent, or breathing embarrassed, chloroform or sulphuric ether may be added at discretion. The mode of inhaling is most important. The patient should be carefully instructed to inspire through the mouth alone, and expire through the nose, as, by this means the medicated air is forced into the remoter air-cells.

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RINGER ON INFLUENCE OF AMMONIA IN CHLOROFORM POISONING.—Dr. Sidney Ringer, in a paper published in the *Practitioner*, June, 1881, p. 437, shows, by experiments, the rapid influence ammonia exerted in a frog's heart, whose action had been arrested by an overdose of chloroform. The chloroform evidently paralyses the heart's muscular substance, affecting the ganglionless and nerveless portion of the ventricle exactly in the same way as any other part of it. [In the *Medical Times and Gazette*, May, 1871, p. 616, Dr. Neild reports a case of apparent death from chloroform inhalation, which recovered from the alarming state of syncope after four half-drachm injections of liquor ammoniæ into the median cephalic vein.

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A novel mode of removing labels from old bottles was suggested by Mr. Chase, at a meeting of the Alumni Association of Massachusetts College of Pharmacy. The face of the label is wet with water, and held for an instant over any convenient flame. The steam or heated water at once penetrates the label, and renders its removal very easy.—*Canadian Pharmaceutical Journal*.



PAGGI ON RESUSCITATION IN CHLOROFORM POISONING BY APPLICATION OF HEAT TO THE PRÆCORDIAL REGION. — Dr. Adolfo Paggi (*Lancet*, June, 1881, p. 1015) refers to a case in his practice while assisting Dr. Labbé, when a patient, under chloroform, ceased to breathe. Artificial respiration and other means, after ten minutes, failed to produce any effect. Dr. Labbé then took a towel, dipped in boiling water, and laid it over the heart. Instantly the pulse and respiration returned. [In the *London Medical Record*, January, 1881, p. 15, Jago's plan of percussing the heart in such cases is noted; and, at p. 57, Dr. Reid's method of giving a hot douche, from a height, to the cardiac region in cases of syncope.—*London Medical Record*.]

## Surgery.

### WHITLOW.

In a clinical lecture on whitlow (*Medical Times and Gazette*, vol. i., 1881, p. 667) Mr. Christopher Heath says that the subject is meagrely treated of in the text-books. If met with in the earliest stage, when the finger has just begun to redden and tingle, a twenty-grain solution of nitrate of silver, or the silver stick wetted and lightly pencilled over the affected part and a little beyond, checks it at once. When the whitlow is a little more severe,—that is, when pus forms about the nail or tip of the finger,—the cuticle, which is insensitive, may be incised. Occasionally, however, when a foreign body has found its way beneath the nail, pus forms there and gives rise to excruciating agony from the tension beneath unyielding structures. Judicious cutting away of the nail will relieve this, if near the margin; but if near the base, it is much better to pare down the nail with a sharp knife until the matter is let out, than to resort to the unnecessary cruelty of removing the entire nail.

The third kind of whitlow is really an acute necrosis of the terminal phalanx, following periosisitis and suppuration beneath the periosteum, just as it does in the case of a long bone.

A very slight injury—the prick of a needle or pin—may set it up. After some hours'

uneasiness, the pain becomes acute and throbbing, and entirely prevents the patient sleeping. If timely relief is not given, pus will very slowly make its way to the surface of the finger, but never up the sheath of the tendons, and, when discharged, will leave the greatest part of the phalanx bare and dead behind it. A timely and free incision is the only mode of saving the phalanx, and cannot be resorted to too early; for, if no pus be present, the inflamed periosteum will still be divided with great relief to suffering. The finger should be held firmly on a table, and the surgeon, entering his knife just above the transverse interphalangeal mark in the skin, should cut boldly down to the bone in its whole length from base to apex. When, as so often happens, these cases have been treated domestically with "soap and sugar" and poulticing until the end of the finger is riddled with sinuses, there is nothing to be done except to extract the necrosed phalanx as soon as it is loose, and to bring the finger into shape by careful water-dressing applied in strips. The base of the phalanx usually survives, giving a point of attachment to the tendons.

Inflammation of the skin, and subcutaneous tissues may occur in any part of the finger. Incisions must here be made with care, so as not to open the theca or sheaths of the tendons, which then invariably slough, and the patient is left with a useless finger. For this reason incisions on each side of the finger are safer than one in the centre, that may unawares let out the tendons, which will look perfectly healthy at the moment, but soon become soddened and softened.

The synovial sheaths of the flexor tendons of the thumb are often, though not always, in direct communication with the synovial membrane of the annular ligament of the wrist, and hence pus is rapidly conducted in this way up to, and, if not relieved, into the forearm.

There is much difference in the importance of saving the different digits. The thumb must be saved at all hazards. The middle and ring fingers are comparatively unimportant, and, if stiff, are apt to be in the way. A stiff forefinger is better than none.—*Philadelphia Medical Times*.

### A MORNING WITH PROFESSOR ESMARCH.

We are indebted to one of the surgeons who took part in the cruise of the Reserve Squadron, under the command of His Royal Highness the Duke of Edinburgh, for the following:

"The Reserve Squadron under the command of His Royal Highness the Duke of Edinburgh arrived at Kiel on the 14th of July. As it had been expected for some days previously, every preparation was made by the good people of Kiel to give us a truly hospitable welcome. Amongst the numerous invitations of various kinds which poured in from all sides, was one to the medical officers of the ships from Professor Esmarch to visit his hospital. On the morning of the 16th, punctually at 8 o'clock, the Professor commenced his first operation—amputation immediately above the knee for strumous disease of the joint. Morphia was given hypodermically, and the patient then chloroformed. His famous elastic bandage was next applied, and the limb amputated by the "circular" method, which is preferred by Dr. Esmarch in such cases, as the muscles are flabby and easily retract. On examining the stump, the bone was found diseased, and two inches more were removed. The vessels were then ligatured, to the number of thirty-seven, with carbolised catgut. Drainage-tubes of decalcified bone were now introduced, and for that purpose an instrument lately invented by Dr. Neuber—*locheisen zur drainage*—was employed. The stump was well syringed with carbolic acid solution; after that, the integument was brought together, the Lister dressing applied, the elastic bandage removed, and the patient taken from the theatre. During the whole time of operating, the air of the theatre was rendered aseptic by carbolised vapour. Professor Esmarch claims for his method the following advantages. It is almost painless, for the previous administration of morphia produces its effect after that of the chloroform passes off, the wound heals without fever or suppuration, and only one dressing is required; moreover, it is bloodless, or nearly so; in the case first operated on, there was only a slight oozing

from the hyperæmic bone. Several patients were now shown to us, in which the success of this method was well demonstrated: a case of removal of the mamma for carcinoma, one of resection of the radius, one of resection of the humerus, a case of removal of a large lipomatous tumour from the back, etc. In all these, only one dressing was applied, and the wound healed without pain, suppuration, or fever. The dressing is left on for fourteen days, and then a little unguentum boracis applied to promote the healing of the epidermis. The mode of dressing differs only from that generally adopted in England in the larger amount of antiseptic material used. In the patient just operated on, the macintosh was first applied, then a thick cushion of jute and carbolised gauze; around this, a thin gauze (carbolised) bandage, then a layer of cotton-wool in the groin, over this a larger cushion, then another gauze bandage. An elastic bandage was now applied, partly for compression (as Dr. Esmarch said), and partly to fix the rest of the dressing. Finally, over all was applied a thin carbolised gauze bandage. Dr. Neuber now showed a glass splint which he has lately invented for resection of the elbow-joint. He has lately used glass splints a good deal, as, in consequence of their being easily cleaned, they are peculiarly well adapted for Lister dressings. Another material much used by him of late for splints is tripolith. It is applied as plaster-of-Paris, and sets in the same way. In consequence of its not absorbing moisture so readily as plaster-of-Paris, it would seem to be particularly well adapted for naval practice. It may be procured from the Gebrüder Schenk, Heidelberg, or from H. Beckmann, 7 (10), Vorstadt, Kiel, who supplies it to the Academy Hospital. Next, Dr. Esmarch conducted us through the wards of the hospital, and exhibited some very interesting cases. Amongst others, two successful amputations at the hip-joint; a case of *nævus*, in which skin-grafting had been done after the plan of Professor Reverdin, of Geneva, who was present, and accompanied us round. We visited next the workshop where all the bandages, etc., are manufactured; then the museum, in which we saw a rich collection of pathological specimens,



and many interesting relics from the fields of battle during the late Franco-German war. What impressed us most during our stay was the earnest, almost chivalrous, devotion to the advancement of surgical science shown by the Professor and all his staff. There is no improvement or new principle of practice advocated by any member of the profession, in any part of the world, that is not canvassed here, and, if worth it, speedily adopted by Professor Esmarch; for, like the clerk of Oxenford in Chaucer,

'Gladly wolde he lerne, and gladly teche.'

A visit to the Naval and Military Hospital, in which we were shown, through the courtesy of the principal medical officer, the medical stores and appliances for the different ships in the German navy, brought to a conclusion a pleasant and instructive forenoon.—*British Medical Journal*.

## A METHOD OF REMOVING THE TONGUE.

BY JAMES TAYLOR, M.R.C.S.,

Surgeon to the Chester General Infirmary.

The operation is performed as follows: An incision about one-sixth of an inch long is made through the skin only from the upper edge of the hyoid bone forwards; this incision is simply to facilitate the passage of the needle. The forefinger of the left hand is passed along the dorsum of the tongue until the point of junction of the tongue and epiglottis is defined; the end of the forefinger is maintained at this point for the present. A strong curved needle, having a length of six inches (exclusive of handle), with eye near the point, and armed with the platinum wire of the galvanic *écraseur*, is passed through the little incision directly backwards in the middle line until the point is felt by the tip of the forefinger of the left hand (in its course the needle, being in the middle line, can by no possibility damage any important tissue). Then the handle is well depressed and the needle pushed on, the point being guarded and guided by the left forefinger until it is protruded through the mouth. The wire is

secured first by a pair of forceps, and then a finger is passed through the loop, the loop drawn forwards, and the needle withdrawn. We have now the loop of platinum wire traversing the base of the tongue directly in the middle line from before backwards, the loop brought forwards through the mouth, and the ends of the wire hanging out of the little incision in front of the throat. The next step is to pass the loop of wire over the apex and sides of the tongue, pulling the ends of the wire at the same time; we thus get the whole tongue encircled by one loop of wire. It is now advisable, but not necessary, to seize the apex of the tongue with a *vulsellum*. Next adjust the ends of the wire to the *écraseur*, connect with the battery, and slowly begin to work. In from ten to fifteen minutes the wire loop will emerge from the little incision, and the now severed tongue being removed by the *vulsellum* from the mouth, the operation is completed.

If the floor of the mouth be affected, so that the loop round the tongue would pass over some diseased portion without including it, this could generally be easily remedied by a preliminary incision beyond the diseased portion, so as to form a groove for the wire loop.—*London Lancet*.

## NERVE-STRETCHING IN LOCOMOTOR ATAXY.

A discussion on this subject was opened by Professor Langenbeck (Berlin), who read a paper in which cases were related in which the operation of nerve-stretching, undertaken to give relief to the pains, had been followed by improvement in the symptoms of ataxy. It seemed as if the stretching of the sciatic nerve led to beneficial changes in the spinal cord.—Dr. Morgan (Manchester) had not had much experience in nerve-stretching; but at the present time he had under his care, at the Manchester Royal Infirmary, a case of idiopathic lateral sclerosis, in which there were characteristic gait, ankle-clonus, increased tendon-reflex, and great pain in both lower extremities. The pains were not relieved by morphia or other drugs. It then occurred to

Dr. Morgan that nerve-stretching would be of service; accordingly his colleague, Mr. Southam, cut down on the left sciatic nerve and stretched it vigorously, so as to raise the patient from the table. Under the influence of chloroform, and before stretching, the ankle-clonus was most marked; but, immediately after stretching, ankle-clonus ceased in the limb operated on, but remained in the right leg. Pain in both legs, however, had disappeared. In the course of a fortnight, the ankle-clonus returned slightly; 60 beats per minute, compared with a previous 120; but there had been no return of pain. Dr. Morgan thought that nerve-stretching in sclerosis, involving the posterior or lateral columns of the spinal cord, was followed by good results. His patient was in all respects better.

Dr. Grainger Stewart (Edinburgh) had met several cases in which pain, with paralysis and other symptoms, showed that there were lesions in the nerves themselves. Of these cases, some had recovered entirely, just as they might occasionally recover in locomotor ataxy. He thought that it would be found that a peripheral affection of nerves existed in these cases, which was quite separate from central changes. The relief obtained by nerve-stretching in these cases was undoubted. —Professor Langenbeck pointed out that the disease might arise from affection of the periphery of the nerves; and that the affection of the spinal cord might be secondary; that the painful condition of the nerves, which was so remarkable and pathognomonic, could be relieved by stretching; and that, by relieving the pains, the morbid condition in the cord was relieved or checked. —Dr. Ogle (London) asked whether nerve-stretching was most beneficial in those cases in which the origin of disease was central, or those in which it was peripheral? —Dr. Brown-Sequard (Paris) pointed out that, in section of one-half of the spinal cord, there resulted hyperæsthesia on the side severed, with anæsthesia on the opposite side; and that, when the sciatic nerve was stretched on that side in which anæsthesia was present, it disappeared, and hyperæsthesia appeared instead, and *vice versa*. —Dr. Langenbeck replied. —*British Medical Journal*.

THE CURE OF VARICOSE VEINS BY SUBCUTANEOUS LIGATURE.—Dr. John Duncan, of Edinburgh, employs carbolyzed catgut for the radical cure of varicocele (*British Med. Journal*). The veins are separated from the artery and vas deferens, and a needle armed with catgut is thrust through at the point of separation; it is then reintroduced at the orifice of emergence, made to pass between the veins and the skin, and brought out at the entrance; the two ends are then firmly knotted together and cut short. By traction on the scrotum the knot is made to disappear entirely, and the punctures are covered with salicylic wool saturated with collodion. The same manœuvre is repeated an inch higher and sometimes a third ligature is advisable. A hard lump of coagulum forms between the ligatures, tender at first, but soon diminishing in size and becoming insensitive. Dr. Duncan treats varicose veins of the leg in the same manner; the introduction of the point of the needle into the aperture of exit of the first puncture and the tightening of the loop of catgut is difficult when there is brawny œdema. In such cases the patient should be kept at rest and an India-rubber bandage applied for a few days. A single ligature is not sufficient, and to close the lumen permanently two must be applied about one inch apart. It is essential that no branch be given off in the segment of vein between the ligatures. —*Cincinnati Medical News*.

THESE are the characters by which you are to recognize a hernia of the Epiploon alone. The tumour is dull, and presents no gurgling on pressure; you will find these signs described in your books, and they are deceptive, for an entero-epiplocele presents these characters; but one symptom, to which I most especially direct your attention, is the narrowness of the pedicle of the hernia, and the almost complete indolence of this on pressure, joined to the absence of a resistant plane behind the ring. This narrowness of the neck is explained without difficulty, when we recall the texture of the Epiploon. We understand very easily that the fat may be depressed by the constricting band, as by a thread. —*M. Desres, in Gaz. des Hôpitaux*.



## MECHANICAL STIMULATION OF THE BRAIN.

Dr. Brown-Séquard recently announced to the Société de Biologie that he has found, in rare cases, a simple puncture or section of the "motor zone" of the brain of the dog, rabbit, or guinea-pig, gives rise to signs of pain, and this when the dura mater has been entirely removed from the region. The sensibility is that of the brain, not of the pia mater, for the surfaces of an incision into the brain substance were found to possess the same sensitiveness. He ascribes it to the congestion induced by the operation, and concludes from it that the congestion may render parts of the brain acutely sensitive, which normally are destitute of sensibility. It has been especially met with when the brain has been exposed for a little time. These observations agree with some made by Dr. Brown-Séquard thirty years ago, showing that the insensitive spinal cord becomes sensitive when it is inflamed. He believes that the movements observed by some experimenters on mechanical stimulation of this part of the brain are simply reflex, and are not due to the excitation of any motor elements.

WHAT is the best method of performing vaccination? This question is often asked by younger physicians, and I do not wonder at it, because little or no instruction is given on this point in our medical colleges. The frequent failures that follow the operation, and often spurious results pronounced genuine, and protective, fully attest the fact that there is a great deal of carelessness, if not downright ignorance, often displayed in the simple, yet important matter of vaccination.—*W. M. Welch M. D., in Phil. Med. Times.*

DR. LEWIS D. MASON, treats fractures of the nasal bones, by passing a steel support, such as a needle or hairlip pin, through the line of fracture, raising the depressed portion. The needle is kept in position by an elastic band, passed over the head and point.—*Western Medical Reporter.*

THE NASHVILLE *Journal of Medicine and Surgery*, commenting upon the case of the wounded President, says: The sublime spectacle of Dr. Bliss scratching the back of the wounded President, so carefully described in the newspapers, puts in a new light the proper function of the medical attendant.

## Midwifery.

### PUERPERAL CONVULSIONS.

Several cases in which pilocarpin, by mouth and hypodermically, was used in eclampsia, are reported with varying results. Langer asserts that it excites uterine contractions and renders them more powerful, and, in two or three cases, as many physicians report a similar result; but Kroner used (*Am. Jour. Obstet.*) injections of pilocarpin in four cases without any appreciable effect upon the uterus, although the toxic effect of the drug was marked.

The weight of opinion seems to favor chloral in large doses by the rectum. Guyot (France) reports remarkable success, thirteen of fourteen cases being saved. He injected into the rectum from one to four drachms in twenty-four hours. Dr. Goodell believes it the best single remedy. He directs a drachm by rectum, or twenty grains by mouth, repeated as often as may be necessary, and asserts that he has never lost a case. Other writers are equally laudatory of chloral, while none discard chloroform. With regard to the induction of premature labor in eclampsia, there seems to be a growing sentiment in its favour, and successful cases are recorded.

Blood-letting is apparently growing in favour again. Many writers advocate it, or at least speak of it as a too much neglected remedy. Dr. C. C. P. Clark (*Am. Jour. Obstet.*) is a strong advocate for the use of morphia in heroic doses. He argues that a woman who bears her pregnancy lightly never has convulsions, hence a prophylaxis consists in removing all irritating conditions. In eclampsia the nervous system is peculiarly tolerant of opiates. Ordinary doses are useless. Inject at once into the arm *a grain and a half of morphia*; should the paroxysm return any time after two hours, repeat the dose. If in labour, repeat the dose in eight hours, any way. He says: "This quantity may look large, but I am perfectly confident, after having tried it many times, that it is perfectly safe. I am almost prepared to swear that twice the quantity, not repeated, would do no harm to a patient in a strongly eclamptic condition."—*DR. HENRY GIBBONS, Jr., Pacific Medical and Surgical Journal.*

### THE PERINEUM.

Much has been written lately of the structure of the perineum, its support during labor, and its immediate repair after laceration. Prof. Thomas, in the new edition of his work on Gynæcology, devotes a chapter to a consideration of the perineal body, and its great importance in sustaining the contiguous structures, and Dr. Henry J. Garrigues contributes a paper of similar import, on the Obstetric Treatment of the Perineum, to the *Am. Jour. of Obstet.*, for April, 1880. These writers both point out the imperfectness of the descriptions of this part of the body in the various works on anatomy. The latter, in particular, seeks to correct many current false impressions. He says: "The fourchette, so generally torn in first labors, is not a fold of mucous membrane, as usually supposed, but is formed of skin. It is, indeed, nothing else than the *commissura posterior*, i. e., the posterior junction of the labia majora; just within is the *fossanavicularis*." The elaborate description of the floor of the pelvis cannot be reproduced here, but it is well worthy of study.

The frequency of the rupture of the perineum is variously stated. In a discussion in the Cincinnati Academy of Medicine, Dr. Tait reported 70 ruptures in 142 primiparæ. Other members believed the accident to occur in 90 per cent. of cases. On the other hand it was stated, that in Prof. Braun's division of the Vienna General Hospital, in 1,157 primiparous cases, rupture occurred but 68 times. This indicates, possibly, a smaller tendency to laceration than exists elsewhere; but it certainly indicates the adoption of more effectual measures to preserve from rupture the perineal body. Dr. Tait attributed lacerations mainly to two causes, rapid deliveries and large heads; but Dr. Whittaker asserted that the head rarely caused rupture. The accident resulted during the escape of the shoulders. He had even seen it caused by the hips. Other speakers corroborated in part this view, but held that lacerations were often begun by the head, and increased by the shoulders.

I think too little importance is attached to the possibility of laceration of the mucous surface of the perineal body, its integumentary

surface remaining intact. I have known and *felt* this to occur repeatedly. The tearing will be readily felt by the hand resting on the perineum. I have known quite extensive lacerations of the vaginal surface, with little or no external appearance of injury. In one instance, the extensions of the nymphæ around the clitoris were torn away, producing great suffering.

With regard to methods for preventing laceration, many are mentioned. They may be thus summarized:

(1) Prevent the rapid descent of the head by pressure upon it, by avoiding the use of ergot, by placing the patient on the left, by dissuading the patient from making voluntary effort.

(2) Relax the vulva and perineum by administering chloroform; by anointing liberally with belladonna; by performing *episiotomy*; by drawing forward, with the hand, the perineum and anus, or the perineum alone by hooking the fingers in the anus (Goodell's plan); by hooking the fingers in the posterior commissure and drawing it backward toward the coccyx with every pain, until the head rests on the perineum.

Dr. Burk, of Rotunda Hospital, urges this latter plan as accomplishing gradually what otherwise is left for the head often to do rapidly. Dr. Reamy, in the discussion above alluded to, considers, and I think quite properly, that too much discredit is cast upon the the forceps in this connection. With the injudicious and hasty, it is true, the laceration is increased, but in the forceps we have a means of regulating and controlling the advance of the head, such as no other method will afford. By the deliberate and cautious use of the forceps, laceration, otherwise inevitable, may even be prevented. So important is the integrity of the perineum considered, that most writers urge an ocular examination of the parts in all cases immediately after delivery. A strong objection to such a rule is the repugnance of both physician and patient to its adoption, but it is not only sanctioned but urged by the leading gynæcologists of the country. Opinion is almost uniform too in favor of the immediate operation for repair of the perineum, even in cases of moderate laceration. — *Pacific Medical and Surgical Journal*.



## POST-PARTUM AND SECONDARY HÆMORRHAGE.

Attention has already been called in another part of this paper to the use of hot water uterine injections in post-partum hæmorrhage. The treatment continues to be extensively advocated. Dr. Lombe Atthill (*Dublin Jour. Med. Science*), states that it is the routine practice in the Dublin Lying-in-Hospital. He gives the following as the result of his experience :

"(1) In case of sudden and violent hæmorrhage in a strong and plethoric woman, it is better to use cold.

"(2) When, from the prolonged or injudicious use of cold, the patient is found shivering and depressed, the beneficial effect of injecting hot water is rapid and remarkable.

"(3) In nervous, depressed, and anæmic women, hot water may at once be injected, without previously using cold.

"(4) In cases of abortion, where from uterine inertia the ovum, although separated from the uterine wall, is wholly or in part retained, the injection of hot water is generally followed by most satisfactory results.

"(5) Where the injection of perchloride of iron is considered necessary, previous injection of warm water clears the uterus of clots, etc., permitting the fluid to come directly in contact with the bleeding surface and lessening the chance of septic absorption.

The injection of tincture of iodine into the uterus has also strong advocates, one writer considering it the most reliable of all measures. He says (*Med. Record*) :

"(1) Iodine controls the hæmorrhage, not by coagulating the blood within the uterus, but by exciting the uterus to contract. The blood is expelled in a liquid form, and hence, instead of having the uterus filled with a mass of hard, sticky clots, ready to undergo decomposition, the uterus is empty and disinfected.

"(2) Tincture of iodine has never, so far as I can learn, caused any bad result, even when injected into the uterus in full strength.

"(3) The iodine treatment never fails to control the hæmorrhage."

The editor of the *Medical Press and Circular* urges the extensive trial of ipecac in nauseating

doses, as advised by Dr. J. H. Carriger, of Tennessee (*N. Y. Med. Jour.*). The remedy is not only anti-hæmorrhagic, but is oxytocic, relaxing and dilating the os, increasing uterine contractions and expulsive pains, and safely and speedily terminating labor.

Dr. I. E. Taylor read a paper at the Academy of Medicine (*N. Y. Med. Jour.*), on "Flagellation, or spanking of the child's back previous to its entire delivery as a means of preventing uterine hæmorrhage; and flagellation of the abdomen of the woman after delivery of the placenta as a substitute for the introduction of the hand into the cavity of the uterus." The title of the paper explains the method advocated by Dr. Taylor. The hips and legs of the child are left within the vagina for twenty minutes or more, while the back is being flagellated. The method serves to stimulate uterine contraction.

Dr. Hanks (*New York Obstetrical Society*) mentioned a case of secondary hæmorrhage after sixteen days, with death of the patient. Dr. Barker thought the result attributable to malarial poisoning, but Dr. Lusk suggested the retention of a supplemental lobe of the placenta as the probable cause.

It is surprising that so little seems to be known or written of the alum plug in uterine hæmorrhages. It appears to me to have advantages over all other methods. In emergencies it is more readily obtainable than hot water or tincture of iodine with the proper syringes to inject; and its use is entirely free from the dangers that attend intra-uterine injections. A piece of alum the size of a hen's egg, smoothed of its sharp edges and thrust into the cavity of the uterus, stops hæmorrhage, causes contraction of the uterus, and prevents septic absorption. Its mechanical presence, and the irritating character of its solution, cause the uterus to contract; this contraction, together with the astringent properties of the alum, stops hæmorrhage immediately; the changes which the blood and discharges undergo through the action upon them of the dissolving alum absolutely prevent putrefaction; and the action of the same alum solution upon any lacerated surfaces, prevents absorption. I have never seen other than the most satisfactory results from this treatment, and feel perfectly safe with any uterine hæmorrhage, if supplied with an alum plug.—Dr. GIBBONS, Jr., *Pacific Medical and Surgical Journal*.

THE CANADIAN  
*Journal of Medical Science,*

A Monthly Journal of Medical Science, Criticism,  
 and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.*

TORONTO, OCTOBER, 1881.

IRREGULAR RENAL ARTERIES.

[ In a paper on "Anatomical Variations," in the *Annals of Anatomy and Surgery*, September, the writer, Dr. Shepherd, McGill College, Montreal, thus speaks of these abnormal conditions: "I have lately, several times, observed that the renal arteries were double, and sometimes treble, and on one occasion I found five arteries given off from the abdominal aorta, and piercing the kidney in various parts. Now, it is important that operating surgeons should be familiar with these various distributions of the renal arteries, especially since nephrectomy has become a recognized operation in surgery, and is so frequently performed. During the present summer session of the medical faculty of McGill University, in my course of operative surgery, whilst performing the operation of extirpation of the kidney, we found that there was no artery entering the hilum of the kidney, but that the organ was supplied by two arteries, one of which entered at the extreme upper end, and the other at the extreme lower end. Not expecting this abnormality, the student who was performing the operation, in clearing the kidney from the tissue round it, tore through the artery supplying the upper end. I merely mention this fact to put operators on their guard, and to draw attention to an important point which has hitherto, as far as I am aware, not been noticed.

Dr. Whitford, of Ottawa, has been appointed chief medical officer of the Manitoba and South western Railway.

THE STUDY OF ANATOMY.

We hope the students in the various medical schools will learn a very important lesson in dissecting, from the proceedings of the last session of the Ontario Medical Council. When the subject of the rejection of many candidates for defective knowledge of anatomy came up for discussion, it was clearly pointed out by numerous speakers, that too much importance had been attached to Gray, and too little to other works on anatomy which are more practical in character. The students when going into the dissecting room should seriously consider this question, and our advice to them is, to work diligently and faithfully on the Cadaver, and use either Ellis or Heath, or text-books of this description, instead of Gray, which for some years has been the favourite book of reference.

CRUDE PETROLEUM AND MALTINE IN PHTHISIS.

—In the August number of this Journal we called attention to the fact that good results had been obtained from the use of crude petroleum in phthisis. We believe this remedy is now much used by American Physicians. One drawback in its use is the difficulty in making it palatable for the patients. Messrs. Reed and Carnrick have succeeded in making an excellent emulsion of maltine and crude petroleum. We have had no experience as yet in the use of petroleum, but we will gladly make a trial of it when thus combined with the maltine the nutrient qualities of which are so well known.

FROM certain correspondence in the English journals, it would appear that Dr. Beard's (New York) much-talked-of experiments in Hypnotism, on a trained subject, at the Waterloo Hotel, Jermyn street, to witness which the nerve and mental savants and notabilities of the Medical Congress were invited, turned out to be a fizzle, or rather an unsuccessful attempt to foist upon a learned assembly, as an experiment and demonstration of scientific precision and rigour, "a performance which would have been contemptible at a village fair, but which was outrageous when brought forward in the guise of science."



COMMUTATION RATES FOR 1882.—We direct attention to the great inducements offered in our list of commutation rates for 1882, which appears in our advertising columns.

WE reproduce from the British journals abstracts of several of the papers read before the recent International Medical Congress, which will be found in the earlier pages of this issue.

PERSONAL.—We are glad to be able to inform our readers that our well-known and highly-esteemed specialist in Ophthalmic and Aural Surgery, Dr. R. A. Reeve, has returned from his trip to Europe, which he speaks of as both a pleasant and a profitable one, including the International Medical Congress, and the special practice of the capitals of the British Islands and the Continent.

Dr. J. R. Jones, for the past fourteen months resident physician of the Hospital for Women, in Soho square, London, England, has returned to Toronto. By dint of diligence and zeal in the discharge of hospital duties, Dr. Jones attracted to himself the friendship and esteem of some of the best medical minds in England, and notably of Drs. Hughlings Jackson, and Sutton, and thereby secured advantages in the study of medicine which fall to the lot of few. We commend the course pursued by Dr. Jones to every Canadian student visiting the Old World; for during the three years and a half of his sojourn there he filled successively, we understand, the posts of clinical clerk, dresser, house physician, house surgeon, and resident accoucheur in the London Hospital, and was for fourteen months, as before stated, resident physician at Soho, "winning golden opinions from all sorts of people." To each one of our students we would earnestly say, "Go thou and do likewise." Dr. Jones' advantages in the field of Nervous Diseases, as well as Gynæcology, have been so exceptional, that we sincerely trust he may be content to cast in his lot with us.

DR. H. G. LACKNER, of Berlin, has been appointed Physician to the House of Industry and Refuge for the County of Waterloo.

It will be seen in the advertisement that Messrs. Lowden & Co., the Toronto agents, will be pleased to send *gratuitously* to physicians, a one pint bottle of any of the maltine preparations on payment of the expressage.

THE well-intentioned and good-natured apologies for Homœopaths, and consultation with Homœopaths, indulged in by Dr. Bristowe and Mr. Jonathan Hutchinson, at the recent meeting of the British Medical Association, have evoked such a storm of professional dissent and righteous indignation as has not been elicited by any question of Ethics for many a day. The universal disavowal of the views entertained by these gentlemen, by the great mass of the body medical, proves conclusively that the general professional conscience is still uninfected, and the ability to discriminate between moral right and wrong as yet intact. The regular Profession to-day declines to recognize "toy medicine and therapeutic jugglery," or to connive at the assumed adoption of an exploded dogma, as strenuously and honourably as ever.

THE LOUISVILLE *Medical News* exhorts all Demonstrators of Anatomy to take accurate notes of all anatomical anomalies met with in the dissecting room, and to pay particular attention to the cases in which these may occur.

Dr. W. B. CONWAY, in the *Virginia Medical Monthly* states that he has found a new anæsthetic in the perfume of the skunk. Two ounces of the fluid was forcibly administered, by inhalation, to a school-boy, by two of his mates. Total unconsciousness ensued, lasting for two hours.

## Obituaries.

WE regret to note the death of Dr. Andrew Chapman, who graduated last spring after completing his course in the Toronto School of Medicine. After receiving his degree he went at once to Muskegon, Mich., where he opened a drug store; and in addition to the management of this business, he engaged actively in general practice, and was succeeding well. He died of Acute Bright's Disease, after a short illness in Muskegon, at the age of 23, and the body was brought to his former home, Ancaster, and buried September 16th.

## Book Notices.

*Forty-Third Annual Announcement of the Philadelphia School of Anatomy, 1881-82.*

*Catalogue of Medical, Dental, Pharmaceutical, and Scientific Publications.* By PRESLEY BLAKISTON, Philadelphia.

*Post-partum Atrophy of the Uterus.* By WALTER COLES, M.D., St. Louis. (Reprint from *St. Louis Courier of Medicine*.)

*Uterine Dilatation with a New Instrument.* By H. P. C. WILSON, M.D., Baltimore. (Reprint from *American Journal of Obstetrics and Diseases of Women and Children*.)

*A Blastoid found in the Devonian Rocks of Ontario.* By HENRY MONTGOMERY, M.A., B.Sc., Lecturer on Zoology and Botany, Toronto School of Medicine.

*Female Diseases, the Result of Errors in Habit and Hygiene during Childhood and Puberty; with Remarks on the Treatment of Rachialgia with Igni-Puncture.* By R. J. NUNN, M.D., Savannah, Ga.

*A Compend of Anatomy.* By JOHN B. ROBERTS, A.M., M.D. Philadelphia: C. C. Roberts & Co.

A short notice of this work appeared in our December number of last year. It seems that the demand for the first edition has necessitated the publication of a second. Of its kind, we can conscientiously say that it is a very good specimen. To the whole tribe of "Handy Books," Remembrancers," "Pocket Anatomists," and "Aids to Anatomy," we object. There is no more royal road to Anatomy than there is to Geometry. Books of this sort are useful only within the four walls of the dissecting-room. A student depending on a book of this kind cannot hope to acquire anything better than that parrot-knowledge, so commonly found in America. The section on Osteology would be improved by a few plates of muscular attachments in the Holden style. As a matter of fact, muscular attachments can be taught in one way only, viz.,

by making the student chalk them out upon the bones themselves. The worst part of the book is the chapter on the Articulations. This very important subject is treated of in seven pages. No mention is made of the movements of each joint, of their nervous and vascular supply, or of the muscles in relation with them. The action of muscles is described in truly laconic style. For example: the pterygoideus externus "draws jaw forwards," no mention, here or elsewhere, of its attachment to the interarticular fibro-cartilage of the temporomaxillary articulation. We are surprised to find in so modern a book no allusion made to Medical and Surgical Surface Marking.

*Lectures upon Diseases of the Rectum and the Surgery of the Lower Bowel.* By W. H. VANBUREN, M.D., LL.D. New York: D. Appleton & Co., 1, 3, and 5 Bond Street, 1881.

This is the second edition, revised and enlarged, of VanBuren's well-known lectures, delivered at Bellevue Hospital Medical College. The work constitutes a complete treatise on the subject, and embodies all the virtues of Curling, Allingham, Cripps, *et hoc genus omne*, together with the author's individual views and experience. The last chapter should undoubtedly have come first, treating as it does of Diagnosis and Exploration, and the Hygiene of the Lower Bowel; while its other contents—Malformations, Impaction, Foreign Bodies, Atony and Neuralgia—might be considered *in primis* as well as elsewhere. But although its location is not rational, no exception can be taken to its matter. The value of Sims's speculum and position in examination of the rectum is strongly insisted upon. In the section on Imperforate Rectum, the author has drawn largely upon Owen's Harveian Lectures. For Constipation in External Hæmorrhoids the author holds the India-rubber tube for self-injection to be the best substitute for drugs; but the recommendation should always be accompanied with the admonition to abandon the practice as soon as possible. As a palliative application in Internal Piles the subsulphate of iron is highly lauded; but in the radical treatment the author prefers ligature to everything else, and Paquelin's Thermocautery next.



After etherization he always forcibly dilates the sphincter, so that it shall not recover its contractile power for a week. An excellent chapter upon Prolapse is presented, and the assertion therein made that the statements of the text-books are misleading as to the infrequency of descent of all the coats of the bowel, and as to the constant presence of a sulcus as indicative of this condition. Polypus is properly, as we believe, stated to be much more frequent than is commonly supposed, especially in children. "A fibrous polypus is always attached well above the sphincters, and a hæmorrhoidal tumour is confined to its own locality below, and has a broad base of attachment." In an admirable chapter upon Abscess, two good old rules are duly enforced, viz., *early* incision, and *always in a line radiating from the anus as a centre*. Free incision of the hard, gristly walls of old fistulæ is highly commended, and for bleeding after the operation the subsulphate of iron in strong solution freely applied, or dusted on in powder, is efficacious and serviceable. In the chapter on Ulcer of the Rectum, dysentery is pronounced to be an unusual cause. Two chapters are devoted to Benign Stricture, and the following classification is adopted:—(1) Congenital (or the Valvular), (2) Cicatricial, (3) Fibrous, and those from proliferation or hyperplastic exudation tending to become fibrous, as in Syphilis. In our opinion, the small round or oval masses of dejecta are no more pathonomic of stricture of the rectum than are the ribbon-shaped. A very necessary caution against the employment of any force in endeavouring to pass a stricture, whether with finger or bougie, is earnestly enforced. "Bougies," it is properly said, "should be slightly conical at the beak, eight or nine inches long, gently curved and constricted at the base, so as not to distend the external sphincter while in place; or else six inches long, conical at either end and introduced within the sphincter." From this description it will be seen how shockingly deficient bougies are as commonly met with in the shops, and our own experience tells us how dangerous they are from their *rectitude* and rigidity. Complete longitudinal section is recommended,

when feasible, as an operation of fair promise in the radical treatment of Benign Stricture; and in doubtful cases excision is advised as an alternative for complete longitudinal section preferable to colotomy. As an antiseptic injection after excision our author declares against thymol as being inferior to carbolic acid in his experience. The lecture upon Cancer is one which every surgeon should read, mark, learn, and inwardly digest; but, in truth, the same remark is equally applicable to the other eleven. The performance of the publisher's part leaves nothing to be desired, and we trust that ere long the volume may be found in the bookcase of every practitioner in the land.

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*A Treatise on Diseases of the Joints.* By RICHARD BARWELL, F.R.C.S. Second edition, revised and much improved. New York: William Wood & Co. 1881.

That, after a lapse of twenty years, in this age of progress a second edition of a standard surgical work should be a desideratum is but natural, and especially is that the case in the subject of joint-disease upon which so much has been written by eminent surgeons since the appearance of Mr. Barwell's first edition in 1861. The labours of a reviewer are in general sensibly lightened when a book has stood the test of twenty years and not been found wanting in anything except those additions and emendations which time and experience render necessary, and in this respect Mr. Barwell has ably done his work. A great point in this book is the care which is taken to give a clear, concise and accurate description of the pathological anatomy of joint-diseases, due credit being given to the opinions of other observers, home and foreign, no matter whether those opinions coincide or not with the author's. Chapter one is devoted to a brief exposition of the normal histology of the various structures entering into the formation of joints. After chapters two and three on simple and suppurative synovitis comes one of the most readable and instructive in the book—that on "Pyæmic Joint-Disease," containing as it does views decided, though to some extent at variance with those held by many on pyæmia and septicæmia, diseases of which so much remains to be discovered.

Mr. Barwell is very decided in his view that pyæmia and septicæmia differ merely in degree and not in kind, and that the cause of the non-appearance of abscesses in all cases of septicæmia is want of time for their formation. As to the embolic theory of pyæmia, it is admitted that such events may occur, but only as complications, not as the essence of the disease. The germ theory is cleverly handled and evidently finds favour, the author believing "that septic poison (infection by micrococci or their emanations) is administered by nature in different doses and in different degrees of strength. "The septic *materies morbi* is evidently but one in kind. The variety in the effects is due in part to the intensity of the poison, but more probably to the receptivity of the individual (the state of his fluids)." It is also stated that the author's investigations so far tend to the view that in pyæmia the living contagion passes into the veins, in erysipelas into the lymphatics. These views Mr. Barwell admits to be speculative as yet, and says that it is certain that microzymes may exist within the body in some fluids, and yet pyæmia be absent; while it is equally certain (Koch) that septic disease may destroy life and yet no bacteria be present. A candid confession and one that is tantamount to saying that though much has been done of late years in this direction, we as yet know nothing conclusive about the origin of septic disease. A strong conviction is, however, expressed that pus-corpuscles found in pyæmic deposits are leucocytes, which altered by the ingress into them of bacteroid germs, have emigrated from the venous radicles, because that change has caused them to conglomerate within the vessels, to form minute thrombi or blocks, and to adhere to the vascular walls, producing stasis, which fails to be inflammatory, not only because the vessel and tissue changes of that process are absent; but also because the blood changes, however, marked are different in kind. The liquor puris is identical with blood serum. The material, therefore, which is deposited from the vessels which we find in the various cavities and justly term pus consists of septically altered leucocytes, suspended in a proportion of serum less than they floated in while still circulating in the vessels.

Our author regards the various joint affections following gonorrhœa, catamenia, labour, exanthemata, etc., all as pyæmic. As to treatment, Mr. Barwell is a strong advocate of carbolic acid, internally, externally, and we may say, eternally, for in the case of wounds he injects into the surrounding tissues above the wound. He uses a tubular needle perforated at the sides and end with a fine rubber tube attached; a glass tube two feet long by three-eighths of an inch in diameter, with one end drawn out to a fine point is filled with a three or four per cent. solution of carbolic acid, and attached to the rubber tube. The needle is then passed deeply into the tissues and the fluid allowed to pass in by gravity. An ounce, it is said, can be injected daily without fear of carbolic poisoning. Quinine in large and frequent doses, and sulpho-carbolate of soda are given internally with benefit. Salicine and its derivatives are powerless to reduce temperature. The usual hygienic and dietetic treatment is advised.

We next come to a capital chapter on strumous synovitis, which calls for no comment save as to the author's views of struma, in which he joins issue with Mr. Holmes' contention that the term is misapplied to joints, because if the part is removed, the disease does not always or often return, and that tuberculosis does not always, nor very frequently occur in children thus affected. Barwell accepts Billroth's definition of struma, and appears to think with Niemeyer that the great danger of strumous persons is that they may become tuberculous. This we think is the view of the majority of recent writers, and is in accord with our own.

In the chapter on hip joint disease we find no mention of Taylor's splint, which is of such great advantage in allowing us to make use of the therapeutic agent in this disease—plenty of pure, fresh air out of doors. Nor does Sayre's come in for more praise, preference being given to extension by a long (and if necessary bracketed) splint, with that miserable make-shift, the perineal band, which English surgeons stick to like a leech.

Barwell totally disbelieves in alleged lengthening in hip disease. Ninety-one illustrations complete the book, which is gotten up in Messrs. Wood & Co's. well-known elegant, library style.



## Meetings of Medical Societies.

### THE AMERICAN DERMATOLOGICAL ASSOCIATION.

THE fifth annual meeting of the American Dermatological Association took place at the Ocean House, Newport, on Aug. 30th, and two following days. The members present were Dr. Hyde, Chicago; Drs. White, Wigglesworth and Grenough, Boston; Drs. Duhring and Van Harlingen, Philadelphia; Dr. Heitzman, New York; Dr. Atkinson, Baltimore, and Dr. Graham, Toronto.

The meeting was called to order on Tuesday morning, when the President, Dr. Hyde, delivered the annual address.

The subject of the address was, "Periodical Dermatological Literature." The speaker divided contributions to Dermatological literature into four categories:

(1.) Solid and praiseworthy observations of facts, or deductions from the observations of others.

(2.) Reprints of imperfectly observed facts.

(3.) Worthless papers of men totally ignorant of the meaning of terms they have attempted to employ.

(4.) Papers written by men, who, from their position, ought to understand the subject, but either from undue haste, or from a foolish desire to identify themselves speedily with the subject on which they write, or from other motives not of the highest character, deluge the medical press with papers, which are often the verbose iteration of what has been written before their day. The speaker referred to the great improvement shown in the Dermatological literature of the last few years.

He then went on to speak of the relationship of Dermatology to general Medicine. It was his opinion that the success achieved in this department had been equal to, if not greater than, that in any other specialty.

Dr. Heitzman then read a paper entitled, "A Contribution to the Minute Anatomy of the Skin." The Dr., in his usual forcible and lucid manner, gave the results of his investigation on the structure of the hair, and its relation to the papilla and hair follicle.

He is of the opinion that the outer root

sheath made by a continuation of the Rete Mucosum, goes to form the sebaceous follicle, and ceases at the bottom of the hair follicle. The inner root sheath, on the other hand, a continuation of the superficial layer of the Epidermis, passes down by the side of the hair to the papilla, and then returns to form the hair itself. The reader exhibited a beautiful section of hair in its follicle, demonstrating his views.

Dr. White, of Boston, read a paper on "The Limitation of Internal Therapy in Skin Diseases." It is impossible to give a summary of this paper, the facts were given in such a condensed form. It will no doubt appear in the Journals, and will well repay reading.

During the evening session, Dr. Van Harlingen read a paper on "Lymphangiosum Tuberosum Cutis Multiplex." The paper was founded on a case which he had under observation for some time. The principal lesions were Lymphangiomata, varying in size, Fibro Molluscous tumour, Telangiectases, and increase of pigment in patches over the body. The reader claimed this to be the third case of the disease on record. The first was described by Kapos in Hebra's work, and the second by Dr. Pospelo, in the "Vierteljahrschrift für Dermatologie."

In the discussion that followed, Dr. Heitzman said that a number of records of cases of Lymphangiosum had been collected by Bilothe's Assistant. They differed, however, in very many features from this case.

Dr. Hyde alluded to Dr. Bussey's work. In the cases described by this doctor there had been an escape of lymph to a debilitating degree.

Dr. Atkinson asked how Dr. Van Harlingen distinguished between Lymphangiosum and Molluscum Fibrosum.

Dr. Wigglesworth spoke of a case described by himself, of Molluscum Fibrosum, in which the symptoms were then described in the paper, viz.: Compressibility, and the appearance of a gelatinous fluid when a section was made.

After further discussion, it was stated that the essential difference between these two kinds of tumours was the presence of Endothelium in

Lymphangiosum and its absence in Mollusum. In Dr. Van Harlingen's case, the Endothelium had not been demonstrated, which the doctor thought might be accounted for by want of care in preparation.

Dr. Duhring read a paper on "The Small Pustular Scrofuloderm." The reader reported the histories of three cases, in two of which there were positive evidences of scrofula, and in the third the diathesis could not be so well made out. The eruption was first papular, then pustular. Scabbing followed, and a cicatrix remained, having a peculiar, star shaped appearance. Each crop of pustules remained for some months. The condition was very rebellious to treatment.

Dr. Heitzman enquired if the eruption resembled the Acne Cachecticum, of Hebra. Dr. Duhring answered in the negative.

Dr. White asked what reasons Dr. Duhring had for distinguishing his cases from Acne Cachecticum. In reply, the Dr. said the follicles were not affected, and the pustules were found in situations where acne seldom or never appears.

#### WEDNESDAY MORNING,

Dr. White presented the report on statistics. He also presented two reports on Leprosy, one from Dr. Foy, of San Francisco, and another from Dr. Graham. In the former, an account of Chinese leprosy, in San Francisco, was given, and in the latter, a short history of the disease in New Brunswick, compiled from the annual reports, which were found in the records of the Provincial Legislature.

Dr. Atkinson then read a paper entitled, "A Case of Tubercular Leprosy." The patient had been under observation for some time. He thought at first it was a sporadic case, but afterwards found that the patient—a female—had lived next door to a man who was affected by leprosy.

The latter was one of those cases, which had been previously reported from that State. Although the reader did not think that there had been any improper relationship existing between these people, he considered the case a most convincing proof of the contagiousness of the disease.

In connection with the paper, Dr. Atkinson

exhibited specimens of what had been described as the Bacillus Lepre.

Dr. Hyde then read a paper entitled "Study of a Case of Acute Tubercular Leprosy." The patient came under his observation during the past year. The disease ran an acute course, proving fatal in six months.

The author, however, thought the disease had existed previously in an unrecognized form. A drawing of the face was exhibited in connection with the paper.

Dr. Hyde then read a paper on, "Pathology of Leprosy," by Dr. H. S. Schmidt, of New Orleans. The paper was founded on the post-mortem examination of three patients. The subject was treated of in the most exhaustive manner.

#### EVENING SESSION,

Dr. White opened the discussion on leprosy. With regard to Dr. Atkinson's case, he did not think the proof of contagion conclusive. He, himself, was becoming more of the opinion that the disease was contagious. As to Dr. Hyde's case, he would enquire if the Dr. had taken into account the possibility of its being a sarcomatous disease.

Dr. Graham referred to reports of Dr. Keys, and of Drs. Bayard and Wilson, on Leprosy in New Brunswick. The former considered the disease contagious, but the latter could find no proof of it in their observations.

Dr. Heitzman referred to the microscopical character of leprosy, and did not think that the paper of Dr. Schmidt, although a very able and exhaustive one, threw any new light on the subject. The Dr., in the course of his remarks, asserted that the cell doctrine was antiquated, and was calculated to obstruct the progress of pathological investigation. He was inclined to think that the true origin of the disease existed in the nerve centres.

Dr. Duhring did not think the evidence of contagion sufficient in Dr. Atkinson's case. He then referred to Dr. Hyde's case, and thought it resembled in some points the case of Fungoid Neoplasm, which he had himself described.

Dr. Hyde, in reply, said he had anticipated differences of opinion in the diagnosis of his case. He had taken in all the possibilities,



and could not think it was other than a case of leprosy. He was willing, however, to rest the final decision on the microscopical examination.

Dr. Wigglesworth then read a paper on, "Buccal Ulcerations of Constitutional Origin." In his paper he strongly recommended for such ulcers, the local application of Iodine Spray, made of tinc. iodine, 5 pts; glycerine, 10 pts.; water, 30 pts. He also recommended the local application of Iodoform, either by brush or by insufflation.

In the discussion, Dr. Greenough spoke of the importance of absolute cleanliness in the treatment of these lesions.

#### THURSDAY MORNING SESSION,

Dr. Heitzman read a paper on the local application of Calcium Oxy-Sulphuret (Vleminkx solution), in a number of skin diseases. He had found its application of special value in acne and rosacea. He had also used it successfully in Psoriasis, Chronic Eczema, and in parasitic diseases. He commenced by using a dilute solution.

Dr. White did not prescribe the preparation on account of its disagreeable odor.

Dr. Heitzman then read a paper on, "Akido Galvanic Cautery in Epilation." He had found most successful results from this mode of operation, and congratulated the profession of America on its invention.

Dr. Heitzman then gave the results of the investigations of the microscopical committee, with regard to the disease Ainhum. The committee were of opinion that the process was not a pathological one, but one of self-mutilation.

Microscopical specimens were then exhibited.

The following are the officers for the ensuing year: President, Dr. Hyde; 1st Vice-President, Dr. G. H. Fox; 2nd, Vice-President, Dr. Hardaway; Secretary, Dr. Van Harlingen; Treasurer, Dr. Atkinson.

J. E. G.

#### TORONTO MEDICAL SOCIETY.

*April 21st, 1881.*

At 8 p.m. the meeting was called to order. The President, Dr. Covernton, in the chair. The minutes were read and confirmed.

Dr. Oldright exhibited a placenta with a peculiar attachment of the membranes.

Dr. Sheard exhibited a stricture of the sigmoid flexure, and rupture of the colon at the junction of the descending and transverse portions.

Dr. Riddel exhibited a triangular plate of fish bone, extracted by means of a piece of bell-wire from the œsophagus of a lady, by whom it had been swallowed.

Dr. Ross, jun., related a case of skin disease.

Dr. Sheard then read a paper upon the pathology of tubercle. The first portion of his paper dealt with the nature of tubercle, and in it he gave the chief histological characteristics of tubercle. In the second portion of his paper he discussed the etiology of the disease, describing the results of experiments upon animals, made with a view of artificially producing tubercle. He advanced the view of a preliminary inflammatory action before the deposit of tubercle, exhibiting a human lung in support of this view, in which the upper part was distinctly tuberculous, and the lower part as distinctly in a condition of red hepatization.

The paper gave rise to considerable and interesting discussion.

The nomination of officers for the ensuing year then took place, and the meeting adjourned.

*May 5th, 1881.*

The Society met at 8.30 p.m. Dr. Covernton, the President, in the chair.

The minutes of the last meeting were read and confirmed.

Dr. Covernton then read his valedictory address, in which he reviewed the status of the medical man, and said that the public did not always appreciate his efforts. He touched upon the benefits of Medical Societies. He reviewed the work done in the past year, and congratulated the Society upon its flourishing condition.

The election of officers for the ensuing year was then proceeded with, which resulted as follows:—Dr. Daniel Clark, President; Dr. Graham, 1st Vice President; Dr. Oldright, 2nd Vice President; Dr. Macdonald, Treasurer; Dr. Alex. Davidson, Recording Secretary; Dr. Sheard, Corresponding Secretary; Drs. A. H. Wright, Lett, and Spencer, Councillors.

Dr. Temple exhibited an acephalous monster, and the meeting then adjourned.

*May 19th.*

The Society met at 8 p.m. The newly-elected President in the chair. After the reading of the minutes, and other preliminary business—

Dr. Oldright, exhibited a bullet which, after passing through several partitions of wood and lath and plaster had inflicted a clearly incised wound on a child's head.

Dr. Cameron related a case of a cherry stone being extruded from an aged person's nose. He could not say how it had got there or how long it had been there, but the patient affirmed that she had not eaten cherries since last November.

Dr. Riddel related a case of confinement in which when he was about to relieve retention of the urine by the catheter, he discovered two large chancres on the labia pudendi.

Dr. Oldright made reference to the painful interest the Society would take in hearing of the illness of Dr. DeGrassi and Dr. McPhedran. The same gentleman also referred to the case of a little girl, two and a half years old, in which there existed an abdominal tumor, principally occupying the right side. It was rapid in its growth, elastic to the touch, but when aspirated it gave no evidence of its being a fluid tumor. A small quantity of fluid withdrawn in the aspirator needle and examined microscopically, did not give any evidence of malignancy. Dr. Workman mentioned a similar case, which proved to be malignant.

Dr. Riddel read an article upon the career of Dr. Tumblety, "the Indian herb doctor," which dilated upon his wonderful cures and his wholesale quackery, after which the Society adjourned.

*June 30th.*

The Society met at 8 o'clock. The President in the chair. The minutes of the previous meeting were read and adopted.

Dr. King was then proposed a member of the Society.

Dr. Sheard exhibited the lung, liver, and kidneys taken from a person the subject of syphilis. The liver contained abscess cavities, the lungs were tuberculous, and the kidneys showed disquamation of the lining of the uriniferous tubes.

Dr. Cameron exhibited a thrombus of the longitudinal series, taken from a child seven months old. He also exhibited the cerebral vessels taken from the same case, with masses attached to them, which he took to be syphilitic germata. The same gentleman also exhibited a portion of a tibia which had been spontaneously amputated at the seat of a malignant ulcer.

Dr. Riddel then related a case of miscarriage at the seventh month, followed by septicæmia, the fetus being a monstrosity.

Dr. Graham then read a very excellent and exhaustive paper upon Leucocy-thæmia, in which he related the histories of two cases which he had recently had under his observation at the Toronto General Hospital, the first case being that of the lymphatic variety. He also referred to the myelogenous form, a very rare variety of leucocy-thæmia. The disease seemed to baffle all treatment, and progressed slowly and surely to a fatal termination. The only treatment thought to be beneficial would be prophylaxis, could the cause of the disease be once arrived at. Chantinoogra oil was tried but with no benefit. The reader,

while he drew a difference between leucocy-thæmia and Hodgkin's disease, thought that the disease under consideration and the so-called malignant growths were related to one another. In concluding his paper, Dr. Graham ventured the following opinions:

1st. That the essential features of leucocy-thæmia are lymphoid deposits, and leucocytu derived from them.

2nd. Similar growths are the features of Hodgkin's disease, but the cells do not enter the circulation.

3rd. That in both diseases the presence of these deposits interferes with the manufacture of the red blood corpuscle, producing anæmia.

4th. That these growths bear a strong relation to malignant growths, especially sarcomata.

5th. That progressive pernicious anæmia may arise as a consequence of leucocy-thæmia or Hodgkin's disease, in the same way that it may follow pregnancy or any other disease which interferes with the proper elaboration of the blood.

The discussion on Dr. Graham's paper was deferred to the next meeting of the Society, owing to the lateness of the hour.

The Treasurer, Dr. Macdonald, then read his report for the by-gone year, which showed the Society to be in a very flourishing condition. It was audited and found correct.

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## Births, Marriages, and Deaths.

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### BIRTHS.

On the 27th August, at 154 Jarvis Street, the wife of Dr. McCollum, of a son.

At 98 Carlton Street, Sept. 18th, the wife of Dr. Marti, of a daughter.

### MARRIAGES.

On the 7th inst., at the residence of the bride's father, Cannington, by the Rev. Joseph Elliott, J. D. Anderson, M.D., L.R.C.P., Edin., of Port Perry, to Mary Miller, eldest daughter of D. Gillespie, M.D.

On the 14th inst., at St. Paul's Church, Woodstock, Ont., by the Rev. J. J. Hill, M.A., Rector, T. Millman, M.D., &c., second Assistant Physician to the Asylum for the Insane, London, Ont., to Helen Dick, only daughter of John Craig, Esq., of Woodstock.

### DEATHS.

At Kingsville, on Monday, August 29th, Esther Wigle, beloved wife of S. A. King, M.D., and daughter of Solomon Wigle, Esq., aged 30 years.

On Sept. 3rd, Annie Isabella, eldest daughter of James Ross, M.D., 92 Sherbourne Street, and widow of the late James Buntin Boyd, aged 25 years.

At Burgessville, on the 6th inst., Arthur Cosby, second son of Dr. James, aged 1 year, 2 months, and 7 days.

On September 13th, at Muskegon, Mich., Andrew Chapman, M.D., aged 23 years, 7 months, and 12 days.



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# THE Canadian Journal of Medical Science.

A MONTHLY JOURNAL OF MEDICAL SCIENCE, CRITICISM, AND NEWS.

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TORONTO, NOVEMBER, 1881.

## Original Communications.

### LEUCOCYTHÆMIA.

BY J. E. GRAHAM, M.D., TORONTO,

Adjunct Lecturer on Medicine, and Lecturer on Clinical Medicine  
and Dermatology, Toronto School of Medicine. (Read before  
the Toronto Medical Society, on June 30th, 1881.)

The histories of the following cases of leucocythæmia are written in extenso, partly on account of the rarity of the disease and partly on account of some interesting pathological conditions which were present. The first case is one of the lymphatic variety, and the second belongs to the splenic form of this disease.

CASE 1.—A. P., æt 26. Admitted to the Toronto General Hospital, November 15th, 1880. He has been employed from boyhood as a painter.

*Family History.*—Father healthy. His mother has been in delicate health for some years. She frequently complains of severe pains in the region of the stomach, which come in paroxysms. One brother suffers from bronchitic asthma. The other members of the family are healthy.

*History of Previous Condition.*—Patient has suffered for some years past from occasional attacks of severe colic, which were always considered to be the result of lead poisoning. His wife states that about two weeks before the commencement of his present illness he took a cold bath when in a heated, perspiring condition.

He is married and has a family of three children. They are all healthy.

The present illness came on three months ago. He complained first of most violent

pains in both hips, running down the thighs to the legs. The pains afterwards extended to the arms. For the first six weeks they were almost always present. Occasionally, however, they became more severe, and would be of the most excruciating character, causing the patient to shout out, roll about on the bed, or on the floor. Paroxysms would sometimes last for hours, and it would require large doses of morphia to relieve them. For the last two weeks patient has been free from pain, but during that time he has been troubled with a sore mouth, and has gradually lost colour. For some days past he has noticed swelling of the legs and feet. Previous to his admission, he had been under the care of Dr. A. H. Wright, from whom much of the information given has been obtained.

*Present Condition.*—The most striking sign present is the patient's appearance. His countenance is of a pale yellow colour, and his cheeks are flabby. The now existing anæmic condition presents the strongest contrast to the previous ruddy look for which he was remarkable when in health. The hair, which is very short, has not grown to any extent during the last four months, it has also changed in colour. The tongue is slightly coated. The gums are swollen and present a pale, rough, granular appearance, and exhibit ulceration in places. They show a strong tendency to bleed. Conjunctivæ are pale. The appetite is poor and the bowels are constipated.

Pulse, 108; resp., 20; temp., 102. The urine is normal in quantity, pale and thick; specific gravity 1020, loaded with uric acid and urates. There is no albumen or sugar. Urea, 23 parts in a thousand.

The lymphatic glands in the neck, axillæ groins and elbows are enlarged. There is swelling and œdema of the legs.

*Physical Examination of the Chest.*—The respiratory sounds are normal, with the exception of a prolonged expiratory murmur heard over the lower part of the left lung posteriorly. Nothing decidedly abnormal about the heart sounds can be discovered. A hæmic murmur is sometimes heard. The abdomen is very much distended, especially in the upper part. Over the stomach there are slight extravasations of blood in the integument, producing discolourations which do not disappear on pressure. The area of hepatic dullness is increased, this is particularly the case over the right lobe. There is a very marked aortic bruit heard most distinctly a little to the left and above the umbilicus.

*Blood.*—A careful examination was made with the microscope. There was a great increase in the white corpuscles and proportional decrease in the red. The proportion was about one to twelve. Not having a hæmacytometer, the corpuscles were not counted.

There is a failure of the eyesight. The hearing is good.

*Treatment.*—Iron, quinine, and nux vomica were given, also pills of aloes and iron when required.

A lotion of borax and chlorate of potash was ordered for the mouth.

Tuesday, November 16th.—Morning, pulse, 108; resp., 22; temp., 100. Noon, pulse, 108; resp., 26; temp., 100½. Evening, pulse, 100; resp., 24; temp., 101.

Wednesday, November 17th.—Morning, pulse, 100; resp., 22; temp., 99. Noon, pulse, 108; resp., 24; temp., 99. Evening pulse, 112; resp., 24; temp., 101.

Thursday, November 18th.—Morning, pulse, 110; resp., 24; temp., 98½. Evening, pulse, 120; resp., 30; temp., 101½.

Examined the blood with microscope. 40 to 70 white corpuscles were found in the field of No. 7. ob. Hartnack.

Friday, November 19th.—Morning, pulse, 120; resp., 24; temp., 101½. Evening, pulse, 125; resp., 26; temp., 102.

The patient has become perceptibly weaker since he came into the hospital and complains of dyspnœa on the slightest exertion.

Saturday, November 20th.—Morning, pulse, 112; resp., 28; temp., 99½. Evening, pulse, 120; resp., 28; temp., 102.

To-day he had a severe attack of pain in the region of the stomach, followed by vomiting. He complains of palpitation. The bones of the hands and arms are especially tender. There is more or less hæmorrhage from the gums. He complains of sleeplessness. His hearing has become somewhat defective. The blood was very carefully examined to-day. Several counts were made. There were about 200 white to 800 red in the field of a No. 8 objective Hartnack.

Sunday, November 21.—Patient had another severe attack of pain to-day, followed by vomiting.

Morning, pulse, 125; resp., 30; temp., 103. Evening, pulse, 120; resp., 30; temp., 100½.

Monday, November 22nd.—Patient remained in bed most of the day. Palpitation and dyspnœa are more marked. The vibices over the chest and abdomen are more prominent. He complains of great thirst and anorexia. Moist rales are heard over the left lung, posteriorly. He complains of a dry, hacking cough. His hearing is somewhat better, but his eyesight is still very poor. He is not able to distinguish objects at a distance.

On examination of the blood we found that the white corpuscles were not so numerous. One white to twenty red.

Morning, pulse, 120; resp., 32; temp., 101½. Evening, pulse, 124; resp., 35; temp., 102.

Ordered to-day a stimulant expectorant mixture.

Tuesday, November 23rd.—Pulse, 121; resp. 36; temp., 100¾. Patient left the hospital. He was in much the same condition as when the last note was made.

Wednesday, November 24th.—Saw the patient at his own home to-day. He appears somewhat better. Pulse, 118; resp., 26; temp., 101. Noticed tenderness and pain over the region of the spleen. The area of hepatic dullness has increased. The action of the heart is laboured. Made a microscopical examination



of blood with much the same result as before. Noticed that the white corpuscles varied in size. Some were large, larger than ordinary, others again were normal in size while those of a third variety were about the size of red corpuscles. There were also microcytes present.

For the last day or two patient has complained of severe pain in the stomach.

Thursday, November 25th.—Morning, pulse, 120; resp., 48; temp., 100. He slept better than usual last night. Breathing is quick and shallow. He still feels pain over the stomach and also in the left side.

Evening, pulse, 120; resp., 36; temp., 100. Patient has vomited at intervals during the day. He had a very good sleep during the afternoon.

Friday, November 27th.—Morning, pulse, 120; resp., 42; temp., 99.5; vomiting continues at intervals. Breathing laboured. Patient complains of extreme weakness. The gums are not so swollen or spongy as formerly. They still continue to bleed occasionally. The tenderness over the hepatic region is not so great, but he complains of great distress in the lower part of the left chest. Ordered pills of morphia and hyoscyam to relieve the pain.

Evening, pulse, 126; resp., 36; temp., 100. Patient much weaker. Vomiting not so severe.

November 26th, morning, 1.—Pulse, 126; resp., 36; temp., 100. He slept moderately well last night. He still complains of severe pain and distress in lower part of left chest.

Evening, 5 p.m.—Pulse, 144; resp., 51; temp., 99. Patient was moderately comfortable until about noon, when he was seized with spasmodic dyspnoea. During the afternoon he had three or four violent spasms accompanied by pain over the epigastric region. When I saw him he had just recovered from one. Pulse exceedingly feeble.

8 p.m.—Patient is suffering from most intense dyspnoea.

9 p.m.—Dr. Reeve examined his eyes with the ophthalmoscope. Owing to the great weakness of the patient the examination could not be made satisfactorily. He found retinitis

with slight extravasations. The blood corpuscles were again counted. There was an immense number of white, and a great diminution of red. From several counts made with a No. 7 ob. Hartnack we found on an average 500 to 300 white. In some fields the white exceeded the red in number.

At 11.30 p.m., patient died. A short time before his death oxygen gas was administered with the object of allaying to some extent the severe dyspnoea.

Autopsy 14 hours after death. Body well nourished. Legs and feet oedematous. On opening the chest and abdomen serous fluid flowed from the cellular tissue. Ecchymotic spots were found on the surface of the liver and on the surface of the right lung, corresponding in situation with the purpuric spots previously described.

Heart enlarged, weight 14 oz. The surface presents a pinkish appearance. In the right ventricle a considerable quantity of partly coagulated blood was found. There were no valvular lesions.

*Lungs*.—The upper part of the left lung was apparently consolidated. This condition arose, to a great extent from oedema. The lower lobe of the same lung presented a remarkably pale appearance, and was more or less solidified. The part was to a great extent devoid of hæmatine as though the circulation had been obstructed in the artery supplying it. The surface was mottled by ecchymotic spots. There were pleuritic adhesions existing between the two lobes. Small lymphoid deposits were found in parts of the diseased lung. Other portions presented the appearance of catarrhal pneumonia.

The right lung was oedematous throughout. The anterior surface was mottled by ecchymotic spots.

Liver enlarged, weight 4lbs. 7oz. It was so firm as to resemble cirrhosis, and rather pale in colour. Microscopical examination demonstrated the presence of lymphoid deposits in parts of the organ. These deposits existed principally in the outer margin of the lobules, but they were also found near the centre. A more detailed description of the morbid anatomy will be found further on.

Spleen, weight 5oz. Firm and œdematous, ecchymotic spots on the surface. On microscopic examination, no marked pathological changes were found.

The mesenteric retroperitoneal glands were much enlarged, and a good deal of inflammatory thickening was found around them. The abdominal aorta was bound down by adhesions the result of inflammatory action in the neighbourhood of the pancreas and mesenteric glands. This constriction was most probably the cause of the bruit heard during life. The lymphatic glands in other parts of the body were enlarged.

Kidneys, 7 oz. each. They were pale and firm. Capsule easily removed; ecchymotic spots were found on the surface of both.

Leucocythæmia in any form is not often met with, and the purely lymphatic variety occurs less frequently than the splenic. The present case appears to belong to the former class. The name lymphatic leucocythæmia is preferable in this case to Hodgkin's disease, as the increase of white corpuscles was one of the most prominent features.

There are a few interesting points in the clinical history. It is doubtful whether the spasms from which the patient suffered some years before his death, and which were diagnosed as lead colic, were not really produced by some inflammatory action in the region of the mesenteric and retroperitoneal glands. The patient himself could not be persuaded that they were from lead poisoning, as he said they were as violent and occurred as often when he was not exposed, as when he worked at his trade. If these spasms were really early symptoms of the disease, the duration would be at least six years.

The attacks of severe pain which marked the outset of the disease could not be accounted for. The pains in the thigh were excruciating and often continued for hours. They were put down at the time to rheumatism, although no swelling of the parts affected could be discovered. Reference will be made to this symptom further on. Another peculiar feature was the interference with the growth of the hair, during the last few months of his life. It not only did not grow, but also became changed in colour, and was dry and brittle. This

circumstance was no doubt due in part to the want of oxygen, as the oxygen carrying the red corpuscles were very much diminished in numbers. This, however, does not account for the hair suffering to a greater extent than the other tissues of the body. An examination of the scalp was made by the microscope, but no pathological changes were discovered. There was no general emaciation up to the last week.

One does not often meet with a case of leucocythæmia of the purely lymphatic variety such as this was, in which the white corpuscles were so numerous as compared with the red. In the count shortly made before death the white were to the red as three to five, while at the same time there was little or no enlargement of the spleen. It must be remembered, however, that the greatest number of the white corpuscles were of the smaller variety.

During the winter session I had also the advantage of observing a case of the splenic form of leucocythæmia. The history is as follows:—

W. T., æt. 57, printer and farmer. Admitted to the Hospital March 1st. The greater part of his life was spent in London, England. He came out to Canada about fourteen years ago, and since that time he has resided in Muskoka, having taken up a farm in the Free Grant District. He was in the habit of spending the winter in Parry Sound, working at his trade. When about twenty years of age he suffered from a slight attack of gonorrhœa. He has been for many years subject to attacks of diarrhœa, coming on without any apparent cause. He has also been subject to boils. With these exceptions he has enjoyed fair health up to the commencement of the present disease. He has never suffered from ague, and the neighbourhood in which he has lived for the last fourteen years is absolutely free from malaria.

Although the patient has had no severe illness, he does not appear to have been a strong man. He states that he was very much overworked when he served his apprenticeship in London. About a year ago he began to complain of hæmorrhoids. Frequent losses of blood from the bowels weakened him very much. About six months ago he noticed a swelling in



the left side, which has increased in size since that time.

*Family History.*—His father and mother are both living; father eighty-one, and mother seventy-six years of age. His father suffered from ague when he was a young man. His grandfather, on his mother's side, died in his ninetieth year. There were twelve children in his father's family, four of whom are dead. One died during infancy, another from some prevailing epidemic. A brother died in India. Another brother died when about twenty years of age, from what appears to have been a large lumbar abscess.

*Present Condition.*—Patient is pale anæmic and considerably emaciated. He is able to walk across the ward and to sit up most of the day. He says he is stronger now than he was three months ago. He is of a nervous temperament, but sleeps well. His breathing is somewhat accelerated. No signs of disease of the lungs could be made out on physical examination. The respiratory murmur is slightly prolonged over the right apex. The pulse is frequent. Number of white corpuscles largely increased, and the number of red very much diminished. One white to fifteen red. The area of cardiac impulse is somewhat increased. A systolic bruit is heard at the base, it is most probably of a hæmic character. A venous hum is heard over the veins of the neck. His appetite is moderately good. He suffers from frequent attacks of diarrhœa. The area of hepatic dullness is markedly increased. On the left side of the abdomen there exists a large, well-defined tumour. From the shape and position of the swelling it is, in all probability, an enlarged spleen. The splenic dullness extends from above downwards at the side from the sixth to some distance below the twelfth rib. The lower margin almost touches the crest of the ilium at a point about two inches behind the anterior process. An idea of the size of the organ may be obtained from the accompanying diagram.

The kidneys appear to be in a healthy condition. The urine contains an excess of uric acid. The following is a record of the pulse, temperature, and respiration, taken for several successive days:—

	Pulse.	Temp.	Resp.
March 3rd.—	108 ....	101½ ....	26
" 4th.—	90 ....	98½ ....	26
" 5th.—	96 ....	99 ....	24
" 6th.—	90 ....	98 ....	27
" 7th.—	90 ....	98½ ....	21

March 8th.—From a count made of corpuscles there was one white to fifteen red. The blood corpuscles in a cubic millimetre: Red 2,695,000; white 24,000.

March 10th. The patient is somewhat better. Proportion of white to red corpuscles, one to eight.

March 16th. The patient is weaker again. Has lately been troubled with nose-bleeding and occasional attacks of diarrhœa. For the first ten days after admission, iron and quinine were given. He is now taking chaulmoogra oil. A liberal diet was ordered.

March 15th. Epistaxis was quite free last night. There was some trouble in stopping it.

June 2nd. Since the last note was made there has been very little change in the patient's condition. The blood corpuscles have been counted several times by Mr. Fletcher. The results will be given in detail. The patient took the chaulmoogra oil for about a month with no beneficial effect. He had to give it up on account of the nausea which it produced. More benefit was derived from iron tonics, etc. He has had the most liberal diet. I do not think there is any improvement since he came into the hospital. On the other hand I do not think he is any worse.

This is a very marked case of leucocythæmia of the splenic variety. There is very little enlargement. The histories of these two cases give one a very fair idea of the two principal forms of the disease: the lymphatic as represented by Case I., and the splenic as represented by Case II. The third, or myelogenous, is a very rare variety.

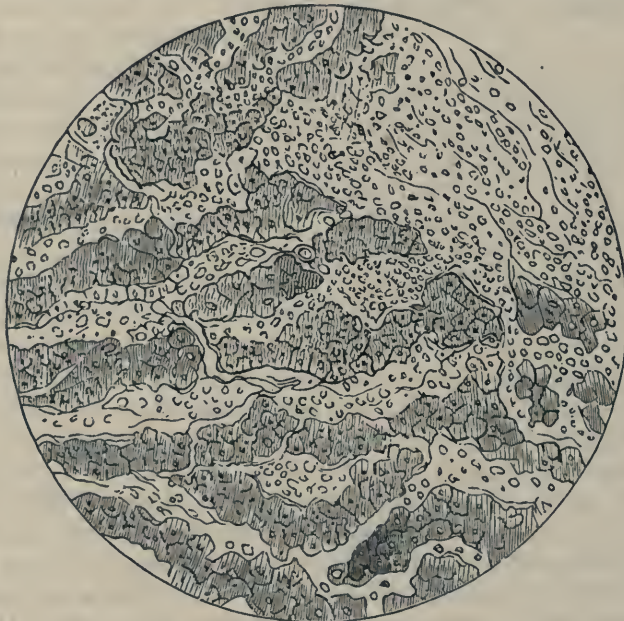
In the post mortem examination of the first patient some peculiar conditions were revealed. The pale exsanguined condition of the lower left lobe could not well be explained. Microscopic examination revealed the presence of lymphoid deposits. It is possible, as was before stated, that an embolus so obstructed the arterial circulation as to cut off the supply of blood.

The deposit in the liver was both localized and diffused, as is shown in the accompanying diagrams. They seem to have been found first in Glisson's capsule, and to have been extended towards the centres of the lobules. In some places the hepatic cells had undergone fatty degeneration. The action of the lymphoid growths on the healthy liver structure resembled very much the hypertrophy of connective tissue in cirrhosis.

The spleen, so far as we were able to judge, was healthy. If there were any lymphoid

cupied by enlarged glands. It will also be noticed in his case that at the onset of the disease, he suffered from most excruciating pains in the limbs. Whether these were caused by any change in the bone structure or not, could not be determined, as no examination was made. It is possible that lymphoid deposits or growths were taking place beneath the periosteum, or in the medulla, at the time. One of the ribs was examined but no pathological changes were found.

In Case II. the diarrhœa, from which the



[FROM A DRAWING BY DR. NEVITT.]

deposits or growths they must have been very slight.

These deposits or growths were also found in the lymphatic glands. The walls of the intestines were not examined.

In Case I. the blood presented corpuscles of different sizes, as has been already described. In Case II. there was not so much difference, the majority being of the normal size.

The clinical histories of both cases were of a typical character. There were, however, in both some peculiar symptoms which preceded the onset of the disease by many years. The first patient suffered for years from violent attacks of pain in the region of the stomach. The situation of the pain was afterwards oc-

patient suffered for years, may perhaps have been due to some tissue changes going on long before the apparent onset of the disease. The question arises whether this may not be a much more protracted disease than we have hitherto supposed, and whether in such cases a diagnosis might not have been made much earlier if the blood had been examined.

The anæmia was much more marked in the lymphatic than in the splenic case. With regard to the causation of this disease, these cases throw very little light. In neither was there any hereditary weakness. In the second case it is possible that hardship endured during his apprenticeship may have been a predisposing cause. The occupation of the first



patient, that of painter, may also have had something to do with the disease.

The pathology of leucocythæmia has not yet been satisfactorily cleared up. The two prominent features are: (1) lymphoid deposits of growths in various parts of body, and (2) increase of white corpuscles in the blood with diminution of red corpuscles. It has been a matter of dispute which of these two conditions precede the other.

I am inclined to think that the lymphoid growths precede the appearance of white corpuscles, and that the white corpuscles are, in very many, if not in all cases, simply lymphoid cells derived from the growths. My reasons for coming to this conclusion are: (1) The varying size of the leucocytes, as seen for instance in Case II. and their exact resemblance in this and every other respect to the cells which go to make up the growths; (2) From the fact that we have a disease (Hodgkin's) in which these lymphoid growths, identical so far as the morbid anatomy is concerned, without the presence of excess of white corpuscles. The question might be asked here, If these two diseases are identical so far as the lymphoid growths are conceived, why should we have leucæmia in one and not in the other? The only way I can see of accounting for this would be that in Hodgkin's disease the cells are so situated that they cannot enter them, and that in leucocythemia they can and do enter the circulation. There is no doubt also that in the latter disease the lymphoid cells, after having been taken up into the circulation, may be deposited in other than gland tissue. In Hodgkin's disease, too, a greater or less number of leucocytes enter the circulation, but not in such enormous quantities as in leucocythemia.

I would be inclined to think then, that in both these diseases there exists previously to their onset a diathesis which may have been present for years; that in Hodgkin's disease the growths take place in the glands without the cells finding their way into the circulation in any number, and that in leucocythemia the growths more often take place in the spleen, and the cells pass in large numbers into the circulation. In both diseases we have an interference in the manufacture of the red corpuscles.

The question might be here taken up as to the relationship which these growths bear to those commonly called malignant, viz., carcinoma and sarcoma. Certainly so far as the clinical history is concerned there is a very striking resemblance between these diseased conditions. In the morbid anatomy there is very little difference between the structure of one of these growths and a round-celled sarcoma. In one we have a slight network of connective tissue, and in the other we have none. In both, the cells enter the circulation and are deposited elsewhere.

Now as to the connection existing between this disease and progressive pernicious anæmia. It is the opinion of some authorities that the latter disease is simply the myelogenous form of leucocythemia. This, as Dr. Howard remarks, in his paper read at the International Medical Congress in 1876, has not been proven.

The chief resemblance existing between the two diseases is the diminution in the number of red corpuscles. It is doubtful if in pernicious anæmia there exist lymphoid growths or deposits, to any extent, in the marrow of bone or elsewhere.

I am inclined to think that the relationship existing between these two diseases is not so striking as has been supposed by some. It is probable, as Dr. Howard concludes, "That all the various forms of anæmia, *e.g.*, forms as determined by the condition under which they occur, may occasionally take on a progressive and pernicious character." It is still doubtful if there exists anæmia as an independent disease. Leucocythæmia, on the other hand, is a pronounced diseased condition, one of the essential and primary features of which is the presence of lymphoid growths. We may have pernicious anæmia as the accompaniment or rather result of leucocythæmia, in the same way as it accompanies pregnancy, but I am doubtful if a true case of leucocythemia has ever resulted from pernicious anæmia.

The prognosis in the disease under consideration is as bad as it can be. Patient No. 2 will, no doubt, soon follow patient No. 1.

As to treatment, no remedy appeared to have the slightest effect. I do not see how we could expect any cure from the administration

of drugs when the disease is seated. We might as well expect to cure a case of malignant growth in a similiar way. By future study of the disease, however, and by a careful collection of clinical and pathological facts, we may arrive at the cause so as to prevent its onset, and thus save the patient from an entirely incurable condition.

In conclusion, from my study of these diseases, I may be allowed to venture the following opinions:—

(1) That the essential features of leucocythemia are the lymphoid growths, and the leucocytes found in the blood derived from them.

(2) That the existence of similar growths is the essential feature of Hodgkin's disease, but in it the cells, for some reason which I cannot explain, do not find the way into the circulation.

(3) That in both diseases the presence of these growths or deposits interferes with the manufacture of the red corpuscles producing anæmia.

(4) That these growths bear a strong resemblance to those of a malignant character, especially sarcomata.

(5) That progressive pernicious anæmia may arise as a consequence of leucocythæmia or Hodgkin's disease in the same way as it sometimes results from pregnancy, or any other condition which interferes with the proper elaboration of the blood.

These opinions I give as the result of very limited opportunities of study, and hope you will receive them as such. I am, however, well aware that somewhat similar conclusions have been arrived at by authorities—Wilkes and Moxon for instance—much more competent to give an opinion than I am.

A measure is before the French Chamber of Deputies, enacting that in future no druggist shall be allowed to combine with his profession that of a doctor, or to sell or advertise any patent medicine or nostrum.

Professor Wm. Warren Greene, of Portland, Maine, returning from the International Medical Congress, died on board the Cunard steamer *Parthia*, and was buried at sea.

## A CASE OF INTRA-CRANIAL DISEASE.

BY WM. CANNIFF, M D., M.R.C.S., ESQ.

Read before the Ontario Medical Association.

The case I am about to bring under the notice of this Association may not be regarded as one of extraordinary interest, but is, I think, of sufficient practical information to warrant me to ask your attention for a brief space of time. Indeed I venture to say my opinion is that unique and startling relations which any one in active practice may select for the consideration of meetings like this, will not best serve to make this Association a success, and secure that mutual advantage which the promoters of it aim to secure for the profession of Ontario. I wish to say, moreover, that my object is not to throw light, but to obtain it; and after I have related the case and the result of the treatment which, I may say, has not been marked by anything unusual, I hope to hear from those present remarks and suggestions of such a practical nature as to afford instruction for future guidance.

The patient of whom I am about to speak has been under treatment in the Toronto General Hospital since the 19th June, 1880, where he is still an inmate. His history, as supplied by himself, is briefly as follows: Aged 31, is a native of Ontario. Since the age of 15 his occupation has been chiefly chopping and hewing timber in the woods in winter, and acting as engineer in mills and factories in summer. Up to the period when he began to work he always had good health, except an attack of scarlet fever when quite young, in connection with which there was nothing particular. In the summer of 1871 he was laid up with typhoid fever, which was prevalent where he lived, and when recovering he suffered a relapse, which was complicated with inflammation of the lungs. He was confined altogether for three months. For a few months before the fever he felt pain in the back of the neck, and easily became tired. Three weeks before the attack he had contracted gonorrhœa. In the fall of '71 he went to the woods, and continued there at work all winter, in good health. The following spring he came to Toronto, with the view of joining the Mounted



Police. He passed the medical inspection, but he, with a number of others, were not required to complete the number needed. He then took a situation as engineer in a steam paper mill, where he remained four and a half years. During that time he was troubled for a while with swelling and pain in the left knee. He noticed at the same time that the leg above and below the knee was smaller than the other. The pain in the knee was at times severe, and continued to trouble him for about two years, gradually getting worse, when he had to give up work. After resting some time the knee got well, and has remained so ever since. He next took a job to clear a field of stumps, and then a contract to build abutments for a bridge, meanwhile remaining quite well. In the autumn of '78 he went to Michigan and engaged in chopping and hewing timber. Towards the first of March he at times found himself dizzy, and if spoken to he could not reply. He "either forgot what he should say or could not get the words out." Would feel hot and a rush of blood to his head. Some days he would have to leave off work before night, but would return to it the next morning. This continued until the 9th April, when in the night he was taken with a fit while asleep. His brother, who was sleeping with him, told him afterward that he made a noise with his throat and that his body was stiff. A doctor, who was called, told him his liver was affected. After this he had great pain in his head, sometimes in the back, sometimes in both temples. He would frequently vomit, especially after eating. This continued for two weeks, when he began to get better, and in a week was out, and at the end of another week returned to work. From this time he continued working all the summer and following winter, having only an occasional headache. In the spring of 1880 he took a job to cut some ship timber, some distance from where he had been working. In going to the new place of labour he noticed a singing in his ears, and found he could not speak, except to say yes or no. If he tried to say more he would make a mistake. The next two days being Saturday and Sunday he felt all right. On the Monday he hewed timber all day; the next day, after working for three hours, he in

a moment found he could not use his left arm and that it had no feeling, but in about half an hour the arm recovered and he resumed work, and continued at it all day; but he had the singing in his ears, and distant sounds seemed near-by and intensified. The following day he had a slight return in the arm at about the same hour. He struggled to overcome the feeling, or want of feeling in the arm, and worked on. At last, suddenly, the left arm was drawn up until the hand was at the shoulder, he then fell to the ground, the left leg having become paralyzed. He was carried to the house, while a greenish fluid oozed from his mouth. He afterwards had an indistinct recollection of what took place, but was unable to speak. In two hours' time he was able to walk, but his arm remained quite paralyzed. Gradually from day to day power returned to the arm; but to the present day its usefulness has remained impaired. This attack, which occurred on the 12th April, 1880, was attended with nausea and vomiting. Similar fits occurred about once a week, and after each the arm for a time was completely powerless. Power of speech was usually lost, and he could not remember names. His condition improved somewhat during the month of May, but his arm was useless for work. On the 17th of June he found his way to the General Hospital. One other occurrence should be mentioned. In the month of February, 1880, while standing in the woods, a limb of dry cedar fell upon him, striking his shoulders and bending him forward to the ground. His head was not touched, and he continued his work. I should also say that about this time he noticed his left eye was affected—he saw double, and to see straight had to shut the left eye. Moreover, he felt the scalp sore to the touch in spots, with a little swelling.

When he came to the Hospital he presented the appearance of a well-nourished young man, with a florid complexion. He had a dull look, and when spoken to answered in a hesitating manner, and his speech indicated partial paralysis of the muscles concerned in articulation. His memory was evidently defective. Nothing abnormal was found to exist in connection with the stomach, bowels, kidneys, or

other abdominal organs. The action of the heart and lungs was natural. His appetite was not very good, but it had been generally very good, but not excessive. The eyes seemed very prominent, and the pupil of the left eye was widely dilated, nor would exposure to light affect it in the least degree. There was a slight contraction of all the flexors of the left arm; the hand was partially closed, and the fingers, especially the little one, firmly flexed. He complained of a dull, heavy pain in the occiput most of the time, and occasionally of sharp shooting pain in the temples. It was some days after his admission before he had a fit. He felt it coming on and laid down. He was convulsed in the left side of the body, but did not lose consciousness; it lasted about fifteen minutes. He described the sensation of an approaching attack, as beginning in the fingers of the left hand, creeping up to the shoulder, and then passing down the side to the foot. Seven weeks later he had another fit, seemingly brought on by stooping over to pick up a child. He felt a rush to his head, tried to walk away but fell in convulsions on the left side. The attack was of short duration. Not long after he was sitting down, engaged in painting a box. The room was close and hot, and he felt the approach of a fit. But he stood up and walked out of the room and upstairs, and it passed away. Two weeks later, on getting out of bed, he experienced a shaking feeling and an odd sensation on the left side of his face, and his tongue felt thick. This lasted only for a few minutes. The last attack approaching to a fit took place last October. But he still has periods of warning, especially when he hears a sudden noise. He described it as a pricking of the nerves, particularly in the arm; and there is occasionally an involuntary winking of the eye. The pupil still remains dilated, but not so much as it was. The arm, as a whole, has mostly regained its power, but the fingers are not under the control of the will. He has been for some time employed in the hospital dispensary, which he keeps in order, and carries the medicines to the patients. He is sometimes forgetful, and gets puzzled. I omitted to mention that shortly after he came in Dr. Reeve instrumentally examined his eyes and found

well-marked optic neuritis of both eyes. Recently Dr. Ryerson used the ophthalmoscope, and he reports: "I examined Cooper's eyes, but did not find any very definite changes. There is some pallor of the left optic disc, but it is not definitely atrophic. His vision is normal. There is diplopia above the horizontal line, indicating lesion of the third nerve."

With regard to the diagnosis: When he came under treatment, although there was much which seemed obscure and uncertain, there appeared sufficient evidence to warrant the opinion that the seat of the disease was at the base of the brain. Many of the symptoms indicated an intra-cranial tumour, or, perhaps, the remains of a blood-clot, or products of chronic inflammation. The possibility of an abscess at first was admitted. I have mentioned that he at one time had gonorrhœa, and he admits to have had it more than once, but I have failed to learn that he ever had syphilis. At first I was inclined to believe from his statements that he had contracted the disease; but the restoration of his memory and clearer statements from him do not support the view of syphilization. While many of the attacks had apparently been excited by what he called a rush of blood to the head, or congestion of the brain, it was apparent that there existed a permanent predisposing cause of the repeated explosions. Respecting congestion of the brain, it may be well here to refer to the lectures recently delivered by Dr. Moxon, before the Royal College of Physicians, "On the Influence of the Circulation on the Nervous System." In these lectures, Dr. Moxon clearly shows that any important increase of blood in the brain is impossible at any time, even when the face and scalp are suffused; but on the contrary that in those cases where it is commonly believed that congestion exists, the brain is deprived of the normal quantity of blood. A few of the symptoms brought to mind that form of convulsive movement known of late as "Jacksonian Epilepsy," in which the spasms are limited to one side of the body, beginning in one limb and spreading to the whole of the one side. This, Dr. Hughlings Jackson regarded as irritation of motor convolutions functionally related to the corpus striatum. But the same careful observer has pointed out the



connection between unilateral fits with double optic neuritis and new growths involving the brain. And Dr. Bramwell, of Edinburgh, says that it is a most important practical fact to remember that double optic neuritis is the most important of all symptoms of intra-cranial tumour, while headache is second in importance, and nausea third.

As to treatment: Absolute rest of body and mind was for some time strictly enjoined, and when he, from time to time, undertook to do anything the warning symptoms clearly showed how necessary it was for him to have complete rest. At first he had only bromide of potash, in doses of grs. xv, every six hours. After a few weeks he had in addition iodide of potash grs. v. per dose. On the 29th September the iodide was increased to grs. x. three times a day. October 22nd proto-iodide of mercury was ordered, which in a week's time caused tenderness of the gums, when it was discontinued. The iodide and bromide were then resumed, grs. x. and xv., and these he has continued to take up to the present. In September a seton was introduced at the back of the neck, where blisters had previously been applied. He felt great relief from the seton, and it remained in for two months. In December, at his own request, another seton was placed in the neck, from which he again found great relief from pain in the head.

I omitted stating that the patient says he rarely takes alcoholic drinks, and never had been using them immediately before any of the attacks.

I may say that the iodide of potash has been used with the view of promoting absorption of any adventitious material, whether specific or otherwise, and the proto-iodide likewise. I was led to employ the seton from experience acquired many years ago when House Surgeon in a New York Hospital, where in a number of instances of chronic brain affections, probably of a syphilitic nature, the use of the seton was followed by marked relief and ultimate recovery.

DISCUSSION.—The President (Dr. Workman) said the case described by Dr. Canniff was one of very great interest, and Dr. C. was deserving of the warm thanks of the Association for the clearness and exactitude of the details furnished

by him; he was, however, strongly inclined to think that the symptoms justified apprehension of a syphilitic complication, and he regarded the adoption of specific treatment, in that relation, as a very judicious decision. We all know that denial of venereal misfortunes by patients is often of questionable reliance. As regarded the cerebral location ascribed to the case by Dr. C., he (the President) was inclined to assign it to the cortex, rather than to the base of the brain. The prodromic sensation mentioned by the patient, as commencing in the fingers, would seem to point to the motor-centre of the arm, as the locality of initiatory morbid disturbance. Ferrier places this centre in the ascending parietal convolution, and I believe he has been sustained in this view by other careful experimenters. It is not, however, improbable, from the aphasic symptoms occasionally observed, that the cerebral trouble extends beyond the motor-centre of the arm, and involves the third frontal convolution. Whether, however, the primary morbid agency may be of syphilitic character, is a question for ulterior decision; but when amelioration or cure follows specific treatment, the presumption of syphilitic influence is very strong.

Dr. McFarlane thought the case to be clearly one of syphilitic origin, but believed the subject of localization of lesion in cerebral tumour to be one of extreme difficulty. He, therefore, would not hazard an opinion as to the precise location of the tumour, but advised perseverance in the anti-syphilitic treatment, with augmentation of the dose.

Dr. Oldright agreed as to the syphilitic nature of the trouble, and would give iodide of potash in large doses as well as mercury.

Dr. Teskey said that from the symptoms observed and related in the paper, one would not hesitate in coming to the conclusion that there existed some intra-cranial lesion, probably a tumour, which would be further confirmed if, by examining the fundus oculi, retinal changes were found. But what is most important in view of treatment is to determine the character of the growth. And first, considering the age of the patient, one would be led to exclude tubercle, aneurysm, and malig-

nant disease, and at the same time to suspect syphilitic deposit; but, in the absence of any reliable history, either for or against that hypothesis, we have the treatment, which has been anti-syphilitic, and attended with marked improvement, thus confirming in some measure such a diagnosis.

Dr. Cameron said the case was interesting, as presenting an example of left hemiplegia with aphasia. The evanescent character of the symptoms pointed to a discharging rather than destroying lesion of the cortex, and their varying and shifting tendency pointed to syphilis. The existence of hemispasm (convulsion), without loss of consciousness, might, perhaps, point to embolism, or vascular obstruction, as Hughlings Jackson held hemiplegia without loss of consciousness did; but certainly the occurrence of headache, nausea, or vomiting, and double optic neuritis, pointed strongly to tumour. The clinical history and transient character of the symptoms, the clearing up of the optic discs between Dr. Reeve's and Dr. Ryerson's examinations, suggested syphilis, and he concurred entirely in the treatment, but would push the iodide to 200 grains a day if need be.

Dr. Temple had recently had three cases of cerebral tumour under his care. One proved fatal, and post-mortem examination disclosed two tumours. The other two cases are still under observation. In the fatal case profound drowsiness with severe headache were the only two symptoms. The patient could be roused, would take food, and at once go to sleep again. In the other two cases, great disturbance of vision is the most prominent symptom. One is so blind that she has to be led about by the hand; general health not bad. In the third case, vision is much disturbed; patient sees objects much distorted, upside down, disappearing and reappearing suddenly; fixed headache is complained of. In all three cases, double optic neuritis existed; in none had vomiting or paralysis been present.

Dr. Canniff replied.

**OPIUM EATING**—Charles Chassignac, in the *N. O. Medical Journal*, reports a case of 20 years' standing, in which 1 dr. of morphia a day had been taken, and 500gr. gum opium. Cured by sudden deprivation.

## NOTES OF THE SECOND DEMONSTRATION IN THE MORBID ANATOMY COURSE IN MCGILL COLLEGE.

BY W. OSLER, M.D., M.R.C.P. LOND.

(Reported by Mr. R. J. B. HOWARD, B.A.)

GENTLEMEN,—I. We are accustomed at the Hospital to recognize typhoid fever by the fever, diarrhoea, and other abdominal symptoms, and by the marked early prostration and muscular weakness which is so familiar to you all. But there are cases of this disease in which the muscular prostration and constitutional affection is so slight, that the patient may never take to his bed. In these ambulatory cases—the typhus ambulatorius of the Germans—the patient, though feeling out of sorts, feverish, perhaps suffering from headache, furred tongue, and diarrhoea, will not give in: he scorns the suggestion of his friends as to “knocking up,” and going to bed: and will go about his work as usual, till forced by weakness or some accident to give in and send for a doctor. I have often observed and pointed out to you, that these cases, when they do succumb to the disease, are apt to suffer a very bad 'bout of it: and the prognosis is unfavourable in proportion as the patient has resisted the onset of the disease.

It was from a case which I believe to have been of this nature, occurring in the practice of Dr. Trenholme of this city, that I obtained the specimen which I will show you in a few moments. Sudden accidents may occur in this ambulatory form: hæmorrhage from the bowels, or intense abdominal pain due to perforation. Such cases are fortunately rare: but not so rare but that you will meet with them occasionally, and probably be much puzzled as to their nature.

In this case the patient was a man 63 years of age, who up to Tuesday had been well: he went about his work on Tuesday as usual, but returned to his home in the afternoon, complaining of great abdominal pain and distress. In the evening he sent for Dr. Trenholme, who informs me that he found the patient pale and collapsed, looking like a cholera patient; but that no alvine dejections were passed. That evening he did pass a large amount of blood.



Next morning he was very much depressed, not feverish, complained of severe abdominal pains. In the afternoon he again passed blood, and died that evening.

At the *post-mortem*, we found the ileum much congested—the mesenteric glands enlarged and deeply engorged. The jejunum presented the numerous diverticula which you saw in the last demonstration. Cutting the bowel open, we found the Peyer's Patches uniformly enlarged, tumified, and presenting an appearance strongly suggestive of typhoid. The surface is cribriform, looking like the top of a thimble. The intervening bridges between the depressions covered with thin grayish-yellow exudation. The solitary glands are much enlarged throughout the entire ileum, while the mucosa is deeply congested. No distinct ulceration exists: only great swelling of the Peyer's Patches, and their cribriform appearance, due to the distention and rupture of the small follicles. The blood doubtless came from the distended capillaries in the Ileum. The spleen was not enlarged, but deeply engorged, and its pulp softened.

Now this I believe to have been a case of ambulatory typhoid, proving fatal from hæmorrhage at an early stage of this disease. I have seen one other case of typhoid fatal by hæmorrhage in the first week. In it there was also no ulceration. In 7 out of 80 fatal cases of hæmorrhage in this disease, noted by Liebermeister, the bleeding occurred in the first week.

II. Last week, gentlemen, I showed you a specimen of aneurysm of the aorta: it was a large saccular aneurysm springing from the transverse arch, and pressing back against the trachea; and I there told you how common these thoracic aneurysms seemed to be in this country. To-day I have another specimen to show you, taken from a patient of Dr. Roddick's. You see that these saccular dilatations spring from the arch in this case. Of these, one springs from the top of the ascending part, and projects to the right side; it displays three or four bulbous dilatations. All of these, and in fact its entire cavity, are filled with firm laminated fibrous clot. From the posterior part of the transverse arch, springs another large sac, the size of a billiard ball, extending between the aorta and the trachea, compressing the lat-

ter tube just at the bifurcation, but no erosion has taken place. The whole arch is dilated; the walls thick and show many gelatinous buttons of atheroma. The great vessels are not involved by the tumors.

Notice, gentlemen, the intima. You see it is uniformly coloured a brilliant red. Such colour is at once associated with active inflammation. I am sure that two-thirds of you would, if asked, tell me that the intima is here acutely inflamed; and a sad mistake you would make. For this colouration has nothing to do with inflammation—it is simply due to post-mortem staining, or imbibition of the blood-colouring matter. The lining membrane of the heart and vessels when inflamed does not show a vivid red. When you see the intima thus stained, it is usually a post-mortem appearance—nor is it usually developed till some days after death, occurring more rapidly in hot weather. In cases of death from septic conditions, you may meet with this staining a very few hours after death, as occurred in a case of septicæmia from acute necrosis of the tibia, in which I found it strongly developed only four hours after death.

The heart, in this case, is quite normal, except for a very little hypertrophy of its ventricles. This illustrates what I told you last week, that in cases of thoracic aneurysm, the heart usually escapes any secondary changes.

As regards the clinical aspect of this case. The symptoms had only lasted some two months. There was the characteristic aneurysmal cough, dyspnoea, pain. On percussing his chest, there was dulness about the first and second bones of the sternum, extending to the right side. But there was no bruit; no abnormal pulsation, that so-called infallible sign; tugging at the trachea did not exist; the pupils were of equal size; and none of the evidences of intra-thoracic pressure existed, other than those mentioned.

I omitted to say that the radial pulse was not quite the same on each side.

I will pass round with this specimen, the one which you saw last week; note especially the condition of the intima, and compare it with the high degree of atheroma in our last specimen. You may notice too, that the whole

aorta is greatly dilated, while in last week's specimen it was not so at all.

III. The specimen I have next to show you, was taken from a woman, aged 40, who was admitted into the hospital with fever, and great pain in her belly. The case was believed to be one of typhoid fever, but, before her death, peritonitis was made out. She was married; had a child a year ago; and, I have learnt that her labour was a difficult one, and her "getting up" slow. Her present illness dates from eight or ten days before admission, she being feverish and complaining of abdominal pains; but she did not take to her bed till a few days before entrance, and she died on the third day in hospital.

Most of you saw the autopsy performed. We found extensive purulent peritonitis; about fifty ounces of thick, creamy pus filled the cavity; the coils of intestines were deeply injected, matted together, and between them pockets of pus existed. On looking for the cause of this condition, no perforation or ulceration could be found in the course of either small or large bowel. But as we approached the sigmoid flexure of colon, we saw a projecting mass lying between it and the psoas; this tumor was soft and fluctuating, and full of pus. It was, in fact, an abscess in the left broad ligament. It did not appear to have perforated, but its wall was soft and infiltrated with pus, and its peritoneal investment was in a state of purulent inflammation. The contents of the pelvis, which I now show you were removed *en masse*. We found abscesses in both broad ligaments. That on the left side was very large, distending the broad ligament, reaching down behind the womb to the level of the os uteri. In the right broad ligament are several smaller abscesses—three of them—quite isolated and distinct. The left ovary was matted into the abscess wall, and quite flattened; the right ovary was healthy.

The womb was enlarged, the endometrium thick, shaggy, and coated with a layer of pus, indicating chronic endometritis.

These abscesses of the broad ligaments are by no means rare; and they often produce just this condition. This they usually do by perforating and discharging into the peritoneal

cavity, when a general peritonitis, of course, ensues. They are themselves usually a sequence of parturition. Probably, in this case, the hard labour set up some parametritis, which passed on to form these abscesses, and they in turn, by perforation, or by mere contiguity, set up the peritonitis. Or the chronic endometritis, which here existed, may have spread through the fallopian tubes to the broad ligament.

The womb shows in its upper and interior part an isolated tumor, of the size of a horse-chestnut. It is an intramural uterine fibroid, or more properly, fibro myoma, and we shall have many examples of this form of neoplasm before this course is ended. The point of interest about this one is, that it is undergoing a change. In places it is soft. It has not the pearly glistening look usual in such tumors, but a dull, opaque yellow hue. In fact it is caseating, which is one of the commonest of the degenerations to which these tumors are prone; another common change being calcification.

Here is the right kidney from the same patient. I have cut it open so as to lay bare the pelvis, and you see inside, three or four hard concretions. These are renal calculi. They are irregular in size and shape, the largest about the size of a bean, and of a light orange-brown colour. There is no history of renal colic in this case. The larger of these stones could not have passed down the ureter, but would probably have produced the changes which follow obstruction of the ureter; these are well illustrated in this plate which I will pass around.

IV. Next, I will call your attention to these organs taken from a phthisical woman, who you remember died in Ward 24, last week. Her lungs showed the usual evidence of the disease in an advanced stage. I shall only show you the apices. In this there is a cavity of the size of a small apple; this has smooth walls, and is lined by a distinct gray pyogenic membrane. About the cavity is much fibrous tissue, and it is to this that I especially call your attention. You see it surrounds, and to some extent, limits the cavity; and it is formed from the thickening of the trabeculae of the lung; it has nothing to do with the pleura.



There are, you see, many small tubercular nodules and peribronchial granulations scattered through the lungs; some caseous nodules as big as peas.

This case illustrates one of the common sequelæ of phthisis, albuminoid degeneration. This occurs usually after chronic suppuration, as in phthisis, bone diseases, and tertiary syphilis. Here we have the spleen and the kidneys affected.

In the spleen only the Malpighian bodies are affected; they are swollen and translucent, looking like boiled sago-grains, whence the name of sago-spleen applied to this condition. In other cases, the process may be more diffused, as in the remarkable case some of you saw last year in the course of these demonstrations. In the kidney, the degeneration usually, as in this case, first affects the Malpighian bodies, and the smallest blood vessels.

Now if you do not recognize this condition with the naked eye, often a very difficult matter, you may definitely ascertain it in one of two ways. You may put a section under the microscope, when the elements will be seen infiltrated with a gelatinous stuff of a waxy look. Or you may apply to a freshly cut surface some fluid which will affect it characteristically. Such a fluid is tincture of iodine. You see when I run some over the surface of this kidney, the healthy tissue is stained a uniform reddish-brown color, while the albuminoid spots become a dark iron or mahogany brown. In the spleen this appearance is even more marked and striking.

The liver in this case was fatty. This is of common occurrence in phthisis, and needs no remark, but you had better examine the specimen sent round carefully, as it is important to at once recognize this common condition.

Now this patient died from acute ulcerative colitis. She complained of great pain, diarrhœa, and dysenteric symptoms. But this does not appear to have been a tubercular colitis at all. The mucous membrane is rough, thick, and studded with countless small ulcers, whose base is hæmorrhagic. The whole gut has a worm-eaten look.

The appendix vermiformis shows an interesting condition in this case. It is large and

dark; presenting no adhesions to other parts. On opening it, the end is distended; half an inch from the end is an ulcer, nearly half an inch in diameter, in the centre of which is a faecal concretion. The ulcer has sharp, clean cut edges, and look how thin the base is; not much here between the peritoneum and the faeces. Now these little faecal concretions often form in the appendix. They cause irritation, and inflammation of the lining wall, and this may lead to ulceration and perforation. Within a year, had this woman lived, she would have died from peritonitis from this cause. The result depends greatly on the situation of the appendix. If between the cæcum and the abdominal wall, it is away from the cavity of the peritoneum; and when perforation occurs, not peritonitis, but perityphlitis is set up. But if it hang free in the abdominal cavity, the result is not so fortunate, for general and fatal peritonitis is sure to follow. It is remarkable in what diverse situations the appendix may lie. In one case in which I performed the autopsy, I found that it was adherent to the lumbar vertebræ, that an abscess had been set up here, that the small bowels were adherent to the walls of this abscess, which had opened into them; and the fatal result was due to hæmorrhage from an eroded mesenteric artery. In other cases the bladder has been the site of adhesion and perforation.

V. Another specimen was submitted for examination while fresh, but the remarks upon it were deferred till a future occasion. It was a case of submeningeal extravasation. The man died from the effects of a fall. The base of the skull was fractured. The blood was spread in a thin layer over the surface of the brain, being thicker over the sulci; and there were several spots of extravasation into the substance. In the very centre of the cerebellum was a large clot, the size of a horse-chestnut.

Dr. H. Hagar recommends that tincture of chloride of iron be mixed with simple syrup and then with milk, this mixture not affecting the teeth nor the usual styptic taste being apparent.—(*Druggist's Circular.*) *Philadelphia Medical Times.*

## SUPRA-PUBIC LITHOTOMY.

BY A. GROVES, M.D., FERGUS, ONT.

Having lately performed the supra-pubic operation in two cases of stone in the bladder, I thought it might possibly be of some interest to the members of this association, to give the method of operating, the after-treatment and the results.

It will be found that the text-books are, as a rule, far from giving proper instructions as to the method of operating. This is perhaps easily accounted for; when it is remembered that few, if any, of our best surgical authors have ever performed the operation. This want of explicit directions in ordinary works must be my excuse for a rather minute account of the manner in which I operated.

The usual preparatory treatment having been carried out, and the time for operating having arrived, the patient is placed on a table of convenient height, in a good light, and is thoroughly anæsthetized. The urine is drawn off, and the bladder partly filled with warm water, which may be carbolized if the operator favours the use of antiseptics. A curved staff—grooved on its concave side to the distance of about two inches, beginning at the extreme point—is now introduced and brought in contact with the stone. Of course the operation must not be proceeded with unless the presence of a stone can be distinctly demonstrated when the staff is passed. The staff is now given into the hands of an assistant; who keeps it in a line parallel with the patient's body, the point directed perpendicularly upwards, and the concavity of the instrument embracing the pubic bone. The supra-pubic region having been previously shaved and oiled, an incision is made in the median line extending upward about three inches from the pubes. The remainder of the cutting should be carried out like a careful dissection—coolly and quietly. After dissecting through any fat that may exist, an opening just large enough to let a finger pass is made through the linea alba and transversalis fascia close to the pubic bone. The point of the staff can now be felt in the bladder, and by using the finger as a guide and director the incision can be enlarged to any required extent without at all

endangering the peritoneum or exposing it to any rough usage. The finger is now pressed gently upon the bladder immediately over the point of the staff, and staff and finger moved in the direction of the fundus to the extent of an inch and a half. A sharp-pointed bistoury is then passed into the groove of the staff just in front of its extreme point, the cutting edge being directed toward the pubes, and the bladder incised as far as necessary. The finger is then passed into the bladder, and the position of the stone ascertained, the staff withdrawn, and the calculi removed by the forceps or scoop. The bladder is then washed out, a soft rubber catheter passed, the patient placed in bed, and a piece of fine sponge inserted in the wound to absorb any urine that may rise into it.

In describing the after-treatment I cannot do better than transcribe the notes of a case which my friend, Dr. J. G. Mennie, kindly took charge of for the first twenty-four hours after the operation. In this case the patient always chilled after an instrument was passed, and consequently it was thought advisable not to leave one constantly in the bladder.

"The operation was finished at 11 a.m., and patient put to bed. At 12 noon, he recovered from the effects of the chloroform, the wound was then dressed by inserting a fresh sponge moistened with a carbolic-acid lotion,—1.40— and also passed a soft rubber catheter, and drew off the urine, which amounted to about four ounces. He was at this time free from pain. At 1 p.m. drew off about  $\text{zviii.}$  of urine. He was still easy, but had an intense desire to pass urine. Pulse 88, and temp.  $99\frac{1}{2}$ . At 1.30 changed the sponge in the wound; and at 2 he passed  $\text{ziii.}$  of urine naturally, and took a severe chill which lasted 20 min., during which warm irons and hot water (in bottles) were applied to the lower extremities, and warm drinks administered. Pulse 92, and temp. 99. At 2.30 he had another chill which lasted a few minutes, returning at intervals. Pulse 95, and temp.  $99\frac{1}{2}$ . At 2.50 he passed  $\text{zii}$  of urine, which caused considerable pain, resembling that previous to the operation, chills still recurring. At 3.30 passed urine, and having at intervals two or three spoonfuls of milk and water, vomited a considerable quantity of fluid.



Changed the sponge. Pulse 100. At 4.05 he appeared to be somewhat easier, and passed about  $\text{ziii.}$  of urine. At 4.45 sponge was again changed, and  $\text{zii.}$  more urine passed. At this time he became fevered, with flushed face and cool hands. Pulse 105, and temp. 100. At 6.00 he passed  $\text{ziii.}$  of urine, wound was cleaned, and a fresh sponge inserted. Fever continued. Pulse 117, and temp. 101. At 6.30 and 7.00 respectively, he passed  $\text{zii.}$  of urine. At 7.30 wound was dressed as before. Still much fevered. Pulse 120, and temp.  $101\frac{1}{2}$ . He was drinking considerable water, and lemon juice—about  $\text{zii.}$  at a time. At 8.20 passed a little urine, and at 9.00 the sponge was changed, and considerable urine taken from the wound. Fever abating. Pulse 110, and temp. 100. At 10.00 much pain accompanied the passing of a little urine. Administered 20 minims tincture of opium, and dressed wound at 11.00. Between 11.00 and 1.00 a.m., he slept 45 minutes, and passed the usual quantity of urine twice. There was a considerable amount of urine in the wound at 1.00. Wound was dressed, and fever much abated. Pulse 98, and temp. 99. Wound was dressed again at 3.00. He obtained short naps, and passed urine. Fresh sponge inserted and wound cleansed at 4.00. At 5.30 the wound was attended to again. Pulse 89, and temp. normal. At 7.00 the wound was cleansed and dressed, patient free from pain. He slept about half an hour between 7.00 and 8.00. At no time after this did the temperature rise above the normal, and after four days a rubber catheter was left in the bladder until the eighteenth day; when the deeper parts of the wound were healed, and he was able to urinate wholly naturally."

The patient in this case was sixty-seven, exceedingly stout—weighing three hundred pounds—and had been a very great drinker. There were six calculi found in the bladder. Five of them measured over an inch each in diameter; the sixth being somewhat smaller. The progress of the case from first to last was most satisfactory—no untoward symptoms arising after the first twenty-four hours.

My next patient was a man of sixty-three; but so broken down and debilitated that he had the appearance of a sickly person of eighty.

His death had been looked for every day during last winter, and his sufferings were very great. In compliance with his most urgent solicitations I operated and removed a stone measuring nearly an inch and a half in its longest diameter. His progress has so far been very good, but the wound is not yet quite healed; as it is only the seventeenth day since the operation.

In concluding this paper, I think I cannot urge too strongly on the members of this Association the advantage of this method of operating. It appears to me that any one who gives it a fair trial will be so satisfied with the results that he will afterward try no other. There are no important structures injured, and no damage incurred in comparison to those of the perineal operation, in which a region filled with veins, arteries, nerves, and lymphatics is cut or torn through. I know that statistics appear to make the supra-pubic a dangerous operation, but on analysing the cases impartially, it will be found that the majority of those who died were most unfavourable ones for any operation, or were those on which the perineal operation had failed; and very many of the minority died from causes not fairly attributable to the method employed. It seems to me that it is not fair to condemn an operation for the unskillfulness of the operator; and for this reason I would eliminate from the statistics those cases of death caused by bursting the bladder by injecting too much fluid into it, also all cases where the peritoneum has been cut, and those where a perineal operation has been performed to allow drainage.

**BIRTH MARKS.**—The following good story is told of a physician of Dayton, Ohio: The doctor was recently attending a case of labour in the family of one of his patrons, who, though a very excellent man, is a little slow in the payment of his medical bills. Immediately after the birth of the babe, the father nervously asked,—"Doctor, is the baby marked?" "Yes," quietly replied the doctor, "It is marked 'C. O. D.'"  
It is needless to add that the bill for that baby was promptly settled.—*Ohio Medical Journal.*

## Selections: Medicine.

### SYMPTOMS OF THE INITIAL PERIOD OF GENERAL PARALYSIS.

BY DR. E. REGIS.

A general paralysis often begins by a stage of functional exaltation, during which the organic functions undergo simultaneously, or singly, an increase of activity.

This exaltation is the result, at the same time, of an inflammatory process which is going on at this epoch in the brain: it is proportioned to the intensity and the energy of the irritative action which is occurring in the superficies of the cerebral convolutions. An important character of the cerebral excitation is drawn from a repulsion for work, which becomes more apparent when the patient has been set to a troublesome and prolonged labour.

The apparatus of vegetative life participates in this excitation of the functions. The temperature in these patients is raised to (38.5°) 101.03. The pulse sometimes is 100. The respiratory movements are repeated up to 40 times a minute, and appetite and thirst are increased.

The urine contains no more urea than formerly, but at times we find there a certain quantity of glucose. The author attributes, perhaps correctly, this glycosuria to the fact that the phlogistic action has extended as far as the floor of the fourth ventricle.—(*La Salute*) *L'Union Médicale*.

INOCULATION OF MONKEYS WITH TUBERCLE.—Some interesting experiments have been performed by M. M. Krishaber and Dieulafoy, on the artificial production of tubercle in monkeys. \* \* \* The conclusions drawn from these investigations are: (1) That human tubercle, when inoculated, kills a monkey in nine out of ten cases, with lesions analogous to those met with in man. 2. The effect of the inoculation varies according to the substance employed; the grey granulation is most, and the pulmonary parenchyma least, infectious. 3. Two monkeys only were found to be insusceptible.—*London Lancet*.

PATHOLOGICAL CHANGES IN THE RETINA ASSOCIATED WITH PROGRESSIVE PERNICIOUS ANÆMIA.—In *Klin. Monats. für Augenheilkunde* (Dec. 1880), Uhthoff describes the changes revealed by the microscope in the retinæ of six eyes removed after death from four cases of fatal pernicious anæmia. They were, 1, hæmorrhages, limited chiefly to the nerve-fibre and intergranular layers, and situated for the most part near the posterior pole, especially around the disk; 2, varicose hypertrophy of the nerve-fibres, affecting chiefly those of the most internal layers, so as to cause them to intrude upon the vitreous body, and consisting chiefly of the often-described shining, or finely granular masses of spherical, or spindle-shaped or retort-like form; 3, homogeneous colloid, or finely granular masses in the inter-granular layer, present in one case only. It seems from these observations that progressive pernicious anæmia must be added to the list of morbid conditions which give rise to a peculiar varicose hypertrophy of nerve-fibres.—*London Medical Record*.

BOVINE TUBERCULOSIS IN MAN.—Dr. Creighton (of Cambridge), thinks that if the view be once adopted, that bovine tuberculosis is communicable to man, the origin of many cases of human tuberculosis hitherto insufficiently explained will be made clear. Cases of abdominal tuberculosis, of tubercle of serous membranes, of general tubercle resembling in its course typhoid fever, and others, will thus receive a new significance. We may also commend to notice his suggestive inquiry as to whether some of the milk epidemics of supposed typhoid may not have been cases of this nature, an inquiry which has received an apt illustration in an outbreak of "tubercular fever" at a school in Bristol, recorded by Dr. W. H. Spencer.—*London Lancet*.

QUEBRACHO.—The results of recent experience with this drug in Bellevue Hospital have been confirmatory of its value in dyspnoea in all its forms. The fluid extract, in doses of from twenty to sixty drops, every hour or two as called for by the symptoms, has been found useful in our hands also, without regard to the exciting cause of the dyspnoea.—*Independent Practitioner—Therapeutic Gazette*.



M. RENDU, in a paper in *L'Union Medicale* upon scrofula and tuberculosis, thus concludes : 1. The so-called tubercular follicle is not a specific element, it is met with in a number of accidental new-formations, and although incontestably more frequent in tubercular products, it cannot be considered as having any absolute value. 2. Scrofula is a veritable diathesis, characterized by a series of variable manifestations upon which it imprints a special physiognomy. The dominant characters of its lesions are indolence and torpidity. 3. Tuberculosis, on the contrary, is not a diathesis ; it presents itself after the manner of parasitic diseases, always ready to break out when the organism is debilitated. 4. The relations of scrofula and tubercle are nothing else than those of the soil and the seed—scrofula the soil, and tubercle the parasitic germ, so much the more invading as the organic foundation is more sterile.

**TYPHOID FEVER WITH LOW TEMPERATURE.**—Frantzel (*Zeit. für Klin. Med.*, Band ii. s. 217) describes severe cases of typhoid fever which attack exhausted individuals, and which run their course with low temperature or without fever, but in which occur general collapse, serious cerebral symptoms, and tendency to gangrene of the extremities, which run a strikingly acute course. Such cases indicate that high temperature is not the only cause of death in typhoid fever, but that cerebral symptoms are of great importance, and that patients even with low temperature must be carefully watched, to preserve them from the many evil consequences of even quiet delirium.—*London Medical Record*.

**COMPRESSION OF CAROTID IN TRIGEMINAL NEURALGIA.**—Dr. Seifert (*Berlin Klin. Wochenschr.*, 1881, No. 11) publishes three cases of trigeminal neuralgia, in which he successfully employed compression of the carotid, as recommended by Gerhardt. The compression was made to last from fifteen seconds to one and a half minutes, and repeated as often as the pain was interrupted, while arsenic and quinine were likewise administered. Gradually, the intervals were lengthened.—*London Medical Record*.

## Surgery.

### ELBOW FRACTURES.

#### FRACTURE OF THE CONDYLES OF THE HUMERUS— TREATMENT BY THE STRAIGHT POSITION.

Reported by Bernard Bartow, M.D.

*Case 1.*—May 14, 1881, A. B., æt. 4, fell from a height of four feet, striking upon her left elbow. I saw the patient six hours afterward and found the left elbow much swollen, the fore-arm flexed at an angle of 30°, the olecranon projecting prominently, as in luxation, the lateral diameter of the joint increased, and movement of the fore-arm accompanied by pain. Further examination showed that the internal condyle was movable, crepitant and displaced. From the character of the crepitus it was evident that the fracture followed, in part, the line of the epiphysis. The attempt was made to crowd the condyle into its place, with the fore-arm extended ; the fore-arm was then placed in the rectangular position, and the whole secured by a piece of belt leather moulded upon the back part and sides of the limb. After 48 hours the splint was removed to examine the joint. The swelling had subsided, but there was a recurrence of the displacement similar to that observed on my first visit. In addition, the muscles contracted, fixing the parts as firmly as if it were purely a dislocation of the fore-arm.

The day following I examined the patient's elbow with the help of an anæsthetic, and then ascertained that both condyles were movable. Crepitus existed between them, as well as between the condyles and the end of the humerus. The diagnosis was, separation, and splitting, of the epiphysis. The spreading of the joint seemed to be due to the crowding apart of the condyles by the flexion of the fore-arm. Firm extension of the fore-arm permitted the easy replacement of the condyles—causing all deformity to disappear. While forced extension of the fore-arm was maintained by an assistant, a piece of moistened belt leather was moulded upon the limb, investing it completely with the exception of a space one inch wide upon its anterior surface. This was secured with a

bandage. The adaptation of the leather to the contour of the limb was perfect; becoming firm in fifteen minutes, all tendency to displacement of the fractured parts was wholly overcome. The limb was maintained in the straight position for two weeks. Strong union having taken place at the end of that time, the fore-arm was flexed to the right-angle position and secured with the same splint, altered to a rectangular one, by cutting a V-shaped piece of leather from its sides opposite the elbow-joint. During the two following weeks the degree of flexion was gradually increased, until the extreme point to which the fore-arm could be bent, was reached. At the end of four weeks the splint was removed, permitting the limb to straighten; a bandage was the only support worn after that time. Six weeks from date of injury the functional recovery of the joint was nearly complete; a loss of about one-fifth of the flexion power was the only impairment of motion. (At the time of writing—four months after the injury—the extent of motion in the elbow-joint of the affected limb, is, in all respects, as perfect as that of its fellow.)

*Case 2.*—June 21, 1881, R. F., æt. 5, fell from a gate upon which he had been swinging, injuring his left elbow. The point upon which the blow was received could not be ascertained. He was attended by Dr. R. H. Hopkins shortly afterward, who diagnosed: fracture of the external condyle, and fracture of the internal epicondyle of the humerus. The line of fracture of the external condyle was partly epiphysial; the epicondyle separation was wholly epiphysial. The displacement of the external condyle was outward and backward; the head of the radius was dislocated and followed the condyle. There was marked increase of the lateral diameter of the joint. The fractured parts were adjusted, the fore-arm flexed at a right angle, and the whole secured with lateral splints of binder's board. Upon examination the second day, the appearance of the joint did not satisfy Dr. H., and he invited me to see the patient with him. The external condyle had become displaced, the head of the radius was prominent, the breadth of the joint was increased, and the fore-arm firmly fixed in its flexed position by the contraction of the mus-

cles. I suggested dressing the fracture with the fore-arm in the straight position. After giving the patient ether, the fore-arm was forcibly extended. This allowed the condyle to be replaced, removing all deformity. While the fore-arm was extended, a leather splint was applied to the entire limb, as in *Case 1*; this secured the fracture perfectly against displacement. On the twelfth day, quite firm union having taken place, the fore-arm was flexed to a right-angle position, and the splint re-applied. The flexion was gradually increased, until the end of the fourth week, when the splint was removed, and a bandage substituted. The motions of the joint were wholly restored at the end of the sixth week. There was no displacement at the points of fracture. In both instances the "carrying function" of the limb was unimpaired.

In a recent paper\* Dr. Allis, of Philadelphia, has shown, in a very able manner, why deformity and ankylosis follow the employment of rectangular splints in the treatment of fractures through the condyles of the humerus. He recommends that such fractures be treated with the fore-arm in the extended position, with a view to preventing displacement of the condyles. In the foregoing cases the treatment has been essentially in accordance with his views. The excellent results obtained in both instances is a good illustration of the correctness of his views.

In the matter of an appliance I prefer a leather splint to the "egg-paste" bandage, or adhesive strips, used by Dr. Allis. The leather can be moulded to fit the arm as perfectly as a paste bandage, requires less time and inconvenience, is stronger, and can be sprung off the arm with great ease for examination of the fracture.

In fracture through the condyles, firm union usually takes place in two weeks. It is unnecessary, therefore, to maintain the limb in the straight position beyond that time. (Dr. Allis recommends that the straight position be maintained for thirty days.) Flexion of the fore-arm at the end of two weeks causes no displacement of the condyles; and by loosening the tissues from adhesions, places the joint in a

\* Trans. Anat. Soc., Jan., 1880.



better condition to resume functional activity, when all restraint shall have been removed.

#### SEPARATION OF THE EPIPHYSIS OF THE LOWER END OF THE HUMERUS.

M. H., aged 6, fell from a velocipede, striking upon the left elbow. She was attended at once by a homœopathic surgeon, who obscurely diagnosed an "elbow fracture" and dressed it with an anterior rectangular splint. The patient was seen by Dr. H. R. Hopkins and myself, eighteen hours after the accident. Then the appearance of the elbow closely resembled luxation of the bones of fore-arm, backward. The muscles had contracted, rendering the fore-arm almost immovable. The patient was etherized, and it was ascertained that there was complete separation of the lower epiphysis of the humerus. The fragment followed the movements of the fore-arm. Crepitus could not easily be obtained by flexion or extension of the fore-arm; but, with the fore-arm flexed, it could be produced easily, by grasping the condyles and moving the fragment from side to side. The tendency of the posterior projection to recur, when flexion was relaxed, and the complete disappearance of the signs of dislocation, when the fore-arm was extended and flexed, confirmed the diagnosis. The fore-arm was placed, semi-prone, in the right-angle position, and the limb dressed in a moulded leather splint embracing its posterior and lateral surfaces. After three days the angle was changed to that of extreme flexion, which angle was maintained until the eighth day, when the fore-arm was extended at an angle of  $40^{\circ}$ . On the fourteenth day union was found to be quite firm, and the fore-arm was brought down to a position of full extension. Passive motion has been practised up to the present time (thirty days from date of injury.) There is no displacement of the epiphysis; flexion and extension are nearly perfect—the only obstacle to free motion being an abundance of inflammatory exudates.

The case is interesting when compared with *Case 1*, in which the epiphysis was split, necessitating a radically different mode of treatment. — *Buffalo Medical and Surgical Journal*.

#### THE SUBJECT OF WOUND TREATMENT AT THE INTERNATIONAL MEDICAL CONGRESS.

THE most important and best sustained of all the discussions took place on Monday morning "on the causes of failure in obtaining primary union in operation wounds, and on the methods best calculated to secure it." Mr. Savory opened it in a very eloquent and philosophic speech, pointing out that primary union was most likely to occur when fresh surfaces are brought together in their natural state, and maintained so without disturbance. The chief cause of failure he believed to be "meddlesome surgery," and essential principles were rest, cleanliness, and asepsis, which admit of almost endless variation in detail. He asked, when a wound was septic or aseptic, was fever, or pus, or only a smell to be the criterion? Defending his Cork statistics, he claimed that they had not been surpassed, though equally good results were obtained by many different plans of treatment, the actual processes of healing being primarily independent of them all. Mr. S. Gamgee followed, and showed the antiseptic absorbent cotton pads he has used with success. As one proof of their antiseptic power, he showed a piece of meat which had been lying between two of them, but exposed to the air for fifteen seconds every day, and was perfectly sweet at the end of twelve days. The principles he laid stress upon were perfect dryness of the wound, thus removing one of the conditions of putrefaction, rest and infrequent change of dressing, circular compression, and suitable position, with the use of antiseptics, as an important adjunct. Dr. Humphry spoke of the importance of a clean-cut wound in healthy tissues, very accurate apposition of the edges and surfaces with very careful closure of all bleeding vessels. The air acting injuriously both as a direct depressant of the vitality of the tissues, and through agents floating in it, it was only wise to use some form of antiseptic to purify the air. For Professor Verneuil, the disposition of the wound and of the patient are the great factors in the healing process. Professor Esmarch's statistics of his own practice are so remarkable, that they must be given in

full. In 398 great operations (six deaths) 85 per cent. of the cases cured healed by first intention with one dressing, in 15 per cent. the dressing was renewed; and this ratio had improved of late. There were 146 excisions of large tumours, 40 excisions of mamma and axillary glands, 14 castrations, with one death from pericarditis and old syphilis, one from apoplexy, one from fatty heart. Of 51 major amputations (thigh 18, leg 27, arm 5, forearm 1), one died from shock and hæmorrhage, and one from delirium tremens. There were 61 resections; 11 exarticulations; 26 necrotomies; 13 nerve-stretchings, one for tetanus, which was fatal; 8 hernias; 21 large cold abscesses; 42 large wounds; 49 compound fractures. The cases were all dressed with pads soaked in iodoform, and absolute alcohol (10 per cent.), fastened on by an iodoform bandage, over that a large pillow of jute and gauze, a moist bandage, and over all an elastic bandage. Professor Volkmann thought that all suppuration is septic, and that personal peculiarity in the main had nothing to do with the healing of a wound. Other evidence was offered and opinions given which only corroborated the above, and supported various ways of carrying out a dry dressing, with rest and compression combined with antiseptics, as advocated by Mr. Gamgee, whose labours in this direction have perhaps not been sufficiently recognized. Professor Lister wound up the discussion. In reference to Dr. Keith's experience, he stated that he had dissuaded him from using antiseptics in the first instance; in such an operation there is abundant room for effusion and means of absorption, while carbolic acid both increases the one and lessens the other; but on the whole he thought antiseptic ovariotomy had been successful. Referring to the experiments detailed at Cambridge which showed that diluted septic poison may be added without effect to blood serum, though not to diluted blood serum, he further recited more recent experiments which showed that blood-clot in the body is still less favorable to the development of organisms. He expressed his belief that it is "solid bits of dirt" that are the deleterious agents, and that possibly too much attention has been paid to the finest particles floating in the air. His own

results, however, were so good that he shrank from giving up any one of the details of the treatment by which he obtained them, although he quite admitted that he too might at some future time be able to say "*fort mit dem spray*"; at present he could not accept irrigation as a substitute for the spray. He denied that there was any ground for the charge that he disregarded the general condition of the patient or his hygienic surroundings. Were this true, his results being so good as admitted by all, what a strong argument it afforded to the efficacy of his merely local treatment! There was no time for Professor Lister to touch upon the many points raised by previous speakers. If we were to attempt to give in a few words the general impression produced by the debate, we should say that the value of antiseptics was clearly recognized by all, that it was made evident that Professor Lister's aim may be attained by means other and simpler than his; that in particular the value of the spray is considered very doubtful; but more than all, that antiseptic treatment only answers one of the requirements of wound treatment, and that he only is a scientific surgeon who enlarges his views and practice to embrace all.—*The Lancet*.

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TREATMENT OF GONORRHEA BY INJECTIONS OF SULPHUROUS ACID AND WATER.—In the *Lancet* for September we find an article on the above subject by W. B. Wilson, M.B., Surgeon-Major. Dr. Wilson has treated sixteen cases of gonorrhœa by injections into the urethra of sulphurous acid and water, diluted 1 to 15, three times a day. Should there be much pain or chordee he uses the injection but once or twice daily. Relapses were few. The majority of cases treated were second attacks. The injection should be superintended by the surgeon lest it might be improperly performed. The purulent discharge soon becomes scanty, and in three days becomes thin and gleety. When this watery condition ensues he employs the remedy but once in twenty-four hours. The patient should be kept quiet, and placed on a moderate diet. Recovery takes place in about six days. Of course the acid should be examined before dilution to know if it is pure.—*Pittsburgh Medical Journal*.



**HANDY METHOD OF APPLYING NITRIC ACID AS AN ESCHAROTIC.**—A Dr. Spiers, having occasion to destroy a nævus, took a two-ounce vial and breaking off the body close to the neck, inverted the latter over the nævus, pressing the rim of glass firmly down upon the skin. This had the effect of forcing the tumor well up into the neck of the vial; and when the acid was applied by means of a pipette, it acted freely upon the whole surface of the nævus. Before removing the vial neck, Dr. Spiers carefully mopped out all excess of acid with some cotton wool on a probe. He then had the satisfaction of seeing a well-defined, circular slough, rather depressed, but with clean-cut edges, as if a punch had been used. The child suffered very little pain, and was easily pacified by being put to the breast. The action of the acid was found to have been entirely confined to the tumor, which was completely obliterated. No cicatricial contraction of the eyelid ensued, and the operation was completely successful.—*New Remedies*.

**EARLY DIAGNOSIS OF FELONS.**—Dr. Adinell Hewson, senior, in a paper in the *College and Clinical Record*, makes use of Delarue's idea of a conical tube, to view the tissue by transmitted light, to aid in the early diagnosis, of felons. In the healthy finger, a bright pinkish red is seen; if engorged the redness deepens; if there is pus in the cellular tissue, the tint will be reddish yellow. If firmer pressure of the finger against the tube remove the reddish colour, and leave it of a more positive yellow, the pus is in the theca of the tendons only, and if the tint under such pressure is of a dirty, or opaque, yellow, the pus is at the bone or periosteum. He uses anæsthesia, produced by rapid breathing, to enable the patient to support the pain of the examination.—*Southern Practitioner*.

**SUN AND AIR.**—When a pert young woman met Sydney Smith on the Downs, at Brighton, she exclaimed, "I have come out to get a little sun and air." "But, madam," replied the mischievous wit, "how is this, I do not see your husband."

## Midwifery.

### OBSTETRIC APHORISMS.

Dr. H. Webster Jones, of Chicago, as Chairman of the Committee on Obstetrics, closed his report to the Illinois State Medical Society, with the following valuable and suggestive sayings. With these as his guide, the practice of the obstetrician of to-day would furnish less work for the gynecologist: 1, an intelligent confidence once established between patient and physician does much to banish the terrors of the lying-in room; 2, it is possible to foresee and prevent the occurrence of the almost fatal form of eclampsia gravidarum; 3, cleanliness is especially next to godliness in the case of the accoucheur, its absence renders one liable to professional homicide; 4, the modern midwifery must not be meddlesome, but must be mediatorial in the sense of palliating suffering, expediting nature's processes by well-proven means, and removing scientifically all inexplicable, accidental, or morbid states and conditions—idleness is no longer an approved qualification for a degree in obstetrics; 5, the hand is the best uterine dilator; 6, the forceps should never be employed until the os uteri is dilated or dilatable, and then not unless the membranes have been ruptured, and labour delayed unnaturally for at least an hour; every practitioner should become skilful in their use, and they should never be left at home for fear of temptation; 7, unnecessary and unavoidable delays in labour are fruitful sources of gynecological practice, they promote inflammation and sepsis; 8, the patient's hopeful confidence, and the physician's industrious attention, actually contribute to the physiological elements of labour; anæsthetics here are, to say the least, superfluous; 9, bi-manual aid in effecting the deliverance of the placenta is not only proper, but advisable; skilfully rendered, the cry of "uterine inversion" becomes no longer a bugbear; 10, the continuous and intelligent counter-pressure over the fundus uteri during the child's exit, the delivery of the placenta and the period of frequent oscillation, be that a shorter or a longer time, is a safeguard never to be neglected; 11, pursuant to the same end,

the application of the bandage, and its continuance, as long as the uterine globe can be felt and embraced by it above the pubis, contributes not only to comfort, but to speedy involution; after the seventh day, close pressure must be interdicted; 12, puffiness of one ankle, with tenderness of the corresponding groin, and an abnormally quickened pulse, with or without copious sweating, noticed within the first ten days after labour, betoken the pressure of phlebitis, and the possibility of embolism or thrombus, and resultant sudden death; 13, the duties of an obstetrician are not concluded until a careful examination, from six to eight weeks after parturition, proves the integrity of the organs involved.—*Medical Record*.

TREATMENT OF POST-PARTUM HEMORRHAGE.—(*Lyon Med.*—Boelz, of Tokio, Japan). The method proposed by the author has, over all other known means, the advantage of being very simple and apparently very efficacious. It consists of tamponing the vagina with the clenched fist, whilst with the other hand we apply the labia majora like a cuff, tightly around the wrist, so that not a drop of blood flows out. During this time an assistant compresses the uterus from above downwards through the abdominal wall, or else applies the vulva around the wrist of the operator, whilst the latter with the free hand compresses the uterus. The method is simple, rapid, may be applied in all cases and really seems to be of great efficacy. Records of numerous cases follow.—*Detroit Lancet*—*Ohio Medical Journal*.

PUERPERAL ECLAMPSIA.—Dr. D. A. Walden, of Beatrice, Neb., writing to the *Chicago Medical Journal and Examiner*, recommends the sulphate of quinine in ten grain doses every two hours, for puerperal convulsions. He reports three cases in which it proved successful after the failure of chloroform by inhalation, chloral in sixty grain doses every two hours, bromide of potash in thirty grain doses every three hours, and morphia sulph. in one grain doses.

## THE CANADIAN Journal of Medical Science,

A Monthly Journal of Medical Science, Criticism,  
and News.

TO CORRESPONDENTS.—We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations.

TORONTO, NOVEMBER, 1881.

### CLINICS IN TORONTO GENERAL HOSPITAL.

We are glad to find that a systematic and complete plan of giving clinical instruction is now being carried out at this Hospital. By an arrangement between the lecturers of the two Schools, which is receiving the active and hearty co-operation of the medical superintendent, two hours and a-half each day, during five days in the week, (from 1 to 3.30 p.m.) are devoted to clinical teaching, a regular programme having been made out, by which certain hours are allotted to the lecturers from the Schools who are on the Hospital Staff. We understand that, with few exceptions, the teachers are making special efforts to prepare and deliver clinics which will be useful and valuable to the students, and are at their posts at the proper time. The want of regularity and punctuality, which was so conspicuous in the past, is, we hope, gone forever. It is not pleasant to call to mind the indifference which has been so frequently shown in the past, by the so-called clinical teachers, towards the students who paid a good price for clinical instruction *which they did not get*. A simple allusion to such injustice will, we trust, place the teaching of the future in a still more favourable light from the marked contrast it will present when compared with the past.

So far as appearance, position, arrangement of different parts and executive management are concerned, this Hospital is, without doubt,



the best in Canada, and being situated in what some are pleased to call the "intellectual capital" of the Dominion, the public and the profession will naturally expect the character of the clinical teaching given within its walls to be at least equal to that of any other hospital in the country, and if the teaching staff will make the effort there is no reason why those indulging in such expectations should be disappointed.

While there is so much to commend in our Hospital management, we regret to have to notice two grave defects. First : There are no hospital records, or none deserving such a name. We think that no other hospital in the world of the same standing is in such a position. We have not space to dilate on the importance of such records. This must be evident to the laity as well as the profession. We have reason to think that the trustees appreciate this fact, and we know that the medical superintendent is very anxious to have reports taken and kept of all the cases ; but he has been compelled to leave this duty in the hands of the attending physicians, who have often tried to have the work done by students, but thus far with very indifferent success, or, rather, with no success at all.

Second : Which is intimately associated with the first ; the students do little or no practical work in the way of surgical dressing or watching and taking careful notes of medical cases. In consequence of this we are ashamed to state that many of our graduates, who have received their instruction in the medical schools and hospitals, are unable to put on the simplest kind of bandage properly when they receive their degrees.

We have associated these two drawbacks, because we think a remedy for the second defect would afford the means of a remedy for the first. If our students did the principal part of the surgical dressing, and visited all patients daily, the regular assistants might spend a portion of their time in keeping records of all the cases ; or half the assistants (say two, supposing four to be employed) might attend to this duty while the others look after the dressings or direct the students who have charge of them. In the Montreal Hospital the plan recently

adopted is something like this, and we learn it is working admirably. Unfortunately it has been found impossible heretofore to get our students to attend to such duties properly, and, therefore, it has been considered unsafe to invest them with such responsibilities. If the students are so blind to their own interests as to neglect such valuable opportunities, and we fear the majority are, we hope the Ontario Medical Council will follow the example of the Royal College and kindred institutions in the Old Country, and require a certificate of having acted for three months in the capacity of clinical clerk, and for the same period as surgical dresser, before allowing them up for the final examinations. As the Council is entitled to the credit of inaugurating practical examinations in Ontario, we hope that it will not be too much to expect this further advance.

We believe the students of this year are as good, if not better, than the average ; but we fear a large proportion of them do not properly appreciate the advantages placed at their disposal. As a rule all who happen to live between Parkdale and Leslieville will rush to the hospital to see a major amputation, while but a small proportion of them will spend fifteen minutes in examining a case of pneumonia or measles. And yet our general practitioners will have many more cases of pneumonia than amputation under their care. We were somewhat recently amazed to see a class of fifteen students, who had followed the physician somewhat hurriedly through a couple of wards, leave, in a body, while a simple fracture of the leg was being dressed, and a few weeks after we had the opportunity of discovering at an examination that not three of them knew how to bandage an ankle. The students should remember that no details of practical treatment are so trifling as to be unworthy of their careful study, and as practical examinations at the bedside have been instituted by both the University of Toronto and the Medical Council of Ontario, a knowledge of practical work which is learned in hospitals is necessary to enable them to pass the dreaded examinations, as well as to prepare them for the more remote, and also more important duties thereafter of alleviating the pains of suffering humanity.

## OPENING OF THE MEDICAL SCHOOLS.

The two medical schools of this city began their winter courses on the 3rd October, when an unprecedentedly large number of students entered upon the course.

With the longer established of the sister schools, the Toronto School of Medicine, introductory lectures have never found much favour, and this year, as is their wont, the individual lecturers entered at once upon the subject of their courses, after saying a few words of welcome, explanation, exhortation, and admonition to the separate classes. The school is in excellent trim throughout, and the greatest enthusiasm prevailing both amongst teachers and students, a most pleasing vista of unbounded future possibilities of utility and attainment opens before it in this last decade of the first half century of its existence.

At Trinity Medical School an introductory lecture was delivered to a large class of students, former students, and a sprinkling of ladies, in the presence of the faculty, Rev. Arthur Baldwin, Rev. Prof. Jones, and Dr. J. H. Burns. The proceedings were opened with prayer by Rev. Mr. Baldwin, after which the Dean, Dr. Geikie, made a few felicitous and felicitatory remarks introducing the lecturer, Dr. Fulton. The lecturer said that in accordance with custom it devolved upon him to deliver the introductory address. He deemed it proper that such an address should partake of a general character, and should not be devoid of advice to students. He would impress upon the younger men the necessity for diligence, application, and unremitting toil for the competition they would meet with in their vocation would be found to be unparalleled in other callings. The facilities for acquiring knowledge were, however, of late, greatly increased. There were numerous qualifications, and different degrees, of success. He commended the motto of Lady Montague, "Hold your ground, and push ahead." It was his duty to admonish his audience, however, that failure was possible in spite of all. He advised concentration, and the avoidance of versatility. He quoted from Michael Fotsers' late address at the International Congress, the

instance of Haller filling many chairs simultaneously, and showing that the progress of science had rendered such a thing no longer possible. Independence, self-reliance, punctuality, and regularity with economy of time, were to be sedulously cultivated, and the evil of procrastination shunned. The faculties of observation, thought, and reason, would need to attain their highest possible development. Amongst the subjects of the course anatomy was pre eminently necessary, and the lecturer hoped that "the slaughter of the innocents" last spring would serve to emphasize the fact. No branch, however, could be neglected with impunity. Powers of clinical observation were of prime importance, and in this respect he advised the students to take Louis as a model. To the final men he would recommend the acquirement of tact, a knowledge of human nature, the quality of decision and presence of mind and a pleasing manner and address. They would find it highly necessary to accommodate themselves to circumstances. The lecturer quoted an aphoristic comparison of talent and tact from Scargill, and pointed the moral of a dissociation of the two by an allusion to Sir James McIntosh's failure in life. Pliableness and versatility were necessary. Politeness, attention to trifles, absence of dogmatism, frankness, cordiality, good humour, and cheerfulness were powerful auxiliaries of success. Syme's well-known advice was approvingly reiterated. Temperance, perseverance, and a recognition of the sweet uses of adversity were important qualities, and their value was illustrated by the citation of points in the lives of Napoleon, Wellington, Webster, Cooper, and Bulwer. If any entered the profession for the sake of money making they would find that medicine was a miserable trade. Valentine Mott advised his students on going out into the world to have two pockets made; a small one for fees, and a large one for abuse. Self-respect was to be inculcated, and a just valuation of self not to be depreciated. Every man owed a debt to his profession, and should maintain its honour and dignity intact, not being carried away by the easy imposition of charlatans upon those who should know better. Trials, difficulties, and responsibilities abounded, but a



good conscience, a good courage, a good training and application would overcome them all. The lecturer concluded an eloquent address by a quotation of the still more eloquent peroration of Sir James Paget's opening speech at the recent International Medical Congress. We deem it a pity that our medical orators on such occasions while striving to imitate his "blanda oratio" and eloquence of diction, do not at the same time seek to cultivate the polished periods, the finished delivery, the gracefulness of manner, and the charm of utterance which have secured to the profession in the old land the honour of a leader whom all men recognize as one of the most brilliant speakers in the nation.

In the attainment of such a purpose these annual addresses might be made to play a no insignificant part. We desire, moreover, to see a perpetuation of such lectures, as serving to show the student that his teachers are acquainted with the trials and perplexities that beset his path, and are in a position to suggest the means of overcoming the one and avoiding the other. Besides, we hold it true, with a recent writer in the *London Lancet*, that it is not wasted time to try at the outset of a career to temper the zeal of youth with the discretion of experience.

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AN EXAMPLE WORTHY OF IMITATION.—In the City of Brussels, whenever a birth is registered the Registrar hands to the parent, gratuitously, a little pamphlet of five pages containing short and plain directions for the management of children. In Paris the mortality amongst infants is so enormous that it is proposed to introduce a similar practice there.

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T. W. MILLS, M.D., L.R.C.P., who was for some time Resident Physician in the Hamilton General Hospital, and recently spent a year in London, England, has returned to Canada, and will live in Montreal. He has been appointed assistant to Dr Osler, Professor of Physiology, in McGill University.

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OPENING OF MEDICAL SESSION OF MCGILL UNIVERSITY.—Dr. F. Buller, Lecturer on Ophthalmology and Otology, delivered the opening lecture on Monday, Oct. 3rd.

### TYPHOID FEVER.

The unusual incidence and prevalence of typhoid fever the world over, so early in the autumn, has, of course, not escaped lay observation and comment, and many are the queries and suggestions dinned into ears medical on all sides, anent the cause and reason thereof. To satisfy public curiosity in the matter, the city editor of the *Globe* has issued post cards, containing a series of questions as to the number of cases seen by each individual practitioner, the locality of their occurrence, the character of the water used—city or well—etc., etc.

We do not believe, however, that any considerable number of the profession, in the absence of any assurance that the data so collected will be weighed and sifted by a competent authority, will entertain sufficient faith in the value or utility of deductions made therefrom to justify them in the very *outré* proceeding of furnishing such information to the secular press. Had the system of disease registration, so zealously inaugurated and energetically pursued by Mr. Monk, continued in satisfactory operation, which we regret to acknowledge is not the case, simply and solely through the absence of the active co-operation of the profession in a matter in which they profess *and feel* a lively interest, we should now be in possession of an accumulation of facts which, properly investigated and judiciously handled, might serve to throw a gleam of light, as far as our Province is concerned, upon the local causes and prevention of a disease whose prevalence is a standing stigma upon the sanitary science, or rather practice, of every community. So far as our city is concerned, our personal observation leads us to believe that the central portions have not suffered in anything approaching a similar proportion to the periphery and outskirts, and if the fact be true it probably is not devoid of interest from an etiological consideration. It is the experience of certain English writers that, during the occurrence of typhoid fever in the cities, diphtheria is unusually rife in the rural districts. We do not know whether the observation be applicable to Canada or not; but certain it is that, although at the present time the mortality in Great Britain and in France from diphtheria frequently

exceeds from week to week the death-rate from enteric fever, we do not in Canada have to bewail a similar experience. Late reports from Greece inform us that in Athens, out of seventy thousand souls no less than four thousand are suffering from typhoid fever. But the reason for this epidemic is not far to seek, it being related that the streets of Athens—proverbially the dustiest and windiest of European capitals—are daily sprinkled with water in which the foul linen of the soldiery and prison-inmates has been washed. Germs of disease being thus sown broadcast on the streets and disseminated by the winds to every quarter, all wonder dies that a fifteenth portion of the population should pay tribute to the avenging Nemesis of municipal madness and outraged common sense.

But in our very midst, though, perhaps on a smaller scale, similar egregious sanitary crimes are daily enacted. In not a few instances this summer have we found, while searching for the cause of individual cases of typhoid, that the infected persons have been living in the immediate proximity of foul privies, that in some the privies were overflowing upon the yards and under the houses; that in some there was reason to believe that milk from an infected dairy was the chief etiological factor; and that in some well water was habitually used, a fact of which, in a city, we are always suspicious, although in these cases no analysis was made. This then is the old story of filth fever; and given the meteorological conditions favourable to the development of zymotic germs, such as we have had this summer in the long drought, it would, to our minds, be strange indeed if enteric fever were not rampant in our midst. Now for the reasons why central portions of the city should suffer less than others. In the first place, privies are less abundant, wells not used, scavenging more thorough; in the second place, city water is more generally employed, and in the third place more lavishly used for all purposes, thus contributing to the constant flushing of the sewers. In a dry season, solid putrescible matters collect at various points in sewers not subject to frequent flushing, and afford a very suitable nidus for the development of germs of all sorts, which then require merely a favouring breeze to waft them

to a soil whose kindly nurture will abundantly attest their deadly character and power.

With regard to the character of the cases in this epidemic, we may add that our experience would lead us to describe them as presenting mild but long-continued fever, considerable prostration, slow pulse, an absence of, or little troublesome diarrhoea, a tendency to epistaxis and intestinal hæmorrhage, and almost constant bronchial complication, but attended with a low death-rate, and satisfactory but prolonged convalescence, except in the cases of short duration which have manifested a liability to relapse.

MESSRS. J. STEVENS & SON, SURGICAL INSTRUMENT MAKERS.—Mr. Stevens, Jun., the Toronto member of this well known firm, has recently been in England, and since his return has largely increased his stock of instruments. We are glad to learn that Mr. Stevens has received sufficient encouragement to induce him to take such a step, and we hope that our readers will not forget that the best class of instruments, of all kinds, can be obtained from this establishment. We have considered it advisable to specially note this fact, because we know that many Physicians and Surgeons, who for years tried in vain to buy suitable instruments in Toronto or other places in Canada, have lately sent to New York or the Old Country for what they required. (See new advertisement in this issue.)

ERRATA.—In our commutation rates published last month, the New York Medical Journal marked "weekly" should be "monthly." The Canadian Journal of Medical Science and American reprint of the London Lancet, will be given for "six dollars" instead of "six and a-half."

DEATH OF PROFESSOR JAMES P. WHITE.—It is with deep and heartfelt regret that we record the death of this eminent and distinguished member of the profession, which occurred in Buffalo, on the 28th September.

The Annual Dinner of the Toronto School of Medicine, will be held at the Queen's Hotel, on Thursday evening, the 10th of November. Messrs. Knill, Coulter, and Draper will act as Chairman and Vice-Chairmen.

The Annual Dinner of the Trinity Medical School, will be held on Thursday evening, November 3rd. Mr. Nattress will act as Chairman.



## Book Notices.

*Transactions of the Medical Association of the State of Missouri, 24th Annual Session at Mexico, Mo., 1881.*

*Ovariectomy during Pregnancy.* By H. P. C. WILSON, M.D., Baltimore. (Reprint from *Gynecological Transactions*, Vol. V.)

*Uterine Massage as a means of treating certain forms of Enlargement of the Womb.* By A. REEVES JACKSON, A.M., M.D., Chicago, Ill. (Reprint from *Gynecol. Trans.*, Vol. V.)

*The Physician's Visiting List for 1882.* Lindsay & Blakiston, Philadelphia.

This well-known Visiting List is at hand, and we have only to say it suits us admirably. It is well arranged, neat, compact, and a good shape for our breast pocket; and so far as we know, our breast pocket is the kind usually worn by our physicians.

*The Compend of Chemistry, &c.* By HENRY LEFFMANN, M.D. Philadelphia: C. C. Roberts & Co., 1881.

The author has faith in the excellence of his little book, and boldly puts it forth upon the world upon its merits, for the sole reason that it suits his pleasure so to do. It appears to be accurate in general, and in detailed descriptions clearness is joined to conciseness. It will, no doubt, prove acceptable to students who have failed to attend carefully to their lectures, or who are cramming for an examination.

*Transactions of the American Gynecological Society, Vol. V., for the Year 1880.* Boston: Houghton, Mifflin & Co.

As a body of Scientific and Practical Gynecologists this society has no superior in any part of the world; in fact, we think it the best in existence. This volume contains the address of the President, Dr. J. Marion Sims, the various papers read by members, together with the discussions, and a complete index to the Gynecological and Obstetric Literature of the year 1879. We must congratulate the able and energetic Secretary, Dr. James R. Chad-

wick, and the publishers, on the general appearance and character of the book in the form in which it is presented to the profession.

*A Medical Formulary, based on the United States and British Pharmacopœias, together with numerous French, German, and Unofficial Preparations.* By Lawrence Johnson, A.M., M.D., New York: Wm. Wood & Co.

This is the May No. of Wood's Library Series for 1881. The design of the work is to present, in a manner convenient for ready reference, the drugs and preparations in common use, together with formulæ illustrating the manner in which they are combined by good practitioners of the present day. Though based on the U. S. and British Pharmacopœias, all the drugs and preparations contained in them are not included, some of the less important having been omitted, and their place supplied by an account of new therapeutic agents. The preparations introduced from the French Codex, and the German Pharmacopœia, are from the last editions of those works, while the unofficial formulæ are derived mainly from recent sources, many of them having been furnished by their authors expressly for this work.

*A Treatise on the Continued Fevers.* By JAMES C. WILSON, M.D., Physician to the Philadelphia Hospital, and to the Hospital of Jefferson Medical College, Lecturer on Physical Diagnosis at Jefferson Medical College, etc. Wood's Library of Standard Medical Authors. New York: William Wood & Co. Toronto: Willing & Williamson.

The author includes among the Continued Fevers, Simple Continued Fever, Influenza, Cerebro-Spinal Fever, Enteric Fever, Typhus Fever, Relapsing Fever, and Dengue. The "Introduction" is written by Dr. DaCosta, who takes for his subject "The Management of Fever," and contains many valuable practical hints on treatment. A work on this subject must necessarily interest the general practitioner, especially at the present time, when continued fever is becoming a scourge to so many communities in this country. In connection with each form of fever we have here historical sketches, discussions on etiology, des-

cription of clinical history, and hints on treatment which are in every case interesting as well as valuable. We feel assured that the book will be one of the most popular (and deservedly so) in this excellent series.

*Coulson on the Diseases of the Bladder and Prostate Gland.* Sixth edition; revised. By WALTER J. COULSON, F.R.C.S., Surgeon to St. Peter's Hospital for Stone, etc. New York: William Wood & Co. Toronto: Willing and Williamson.

This is the July volume of Wood's Library of Standard Authors, and the sixth edition of the work. Although the general plan is the same as that of the fifth edition, which was published more than twenty years ago, numerous additions have been made, and most of the old chapters have been re-written. In the portion devoted to the bladder, which includes nearly the whole book, the author first gives anatomical and physiological considerations, next methods of making examinations, and after a chapter on abnormalities, goes on to give a description of the various injuries and diseases, together with appropriate treatments, which is thoroughly comprehensive and exhaustive. In addition to his own views on various questions, he quotes largely from all the recognized authorities in this department. While according a hearty approval to everything written respecting the bladder, we regret we cannot say so much for the few short chapters on Affections of the Prostate Gland, which are meagre and common-place in every respect.

*A Practical Treatise on Impotence, Sterility, and Allied Disorders of the Male Sexual Organs.* By SAMUEL W. GROSS, A.M., M.D., with sixteen illustrations. Philadelphia: H. C. Lea's, Son & Co. Toronto: Hart & Co.

This little brochure of 170 pages is conceived and executed in a scientific spirit, and may do good service in directing attention to the fact that in a considerable proportion of unfruitful marriages the husband is really the delinquent; our author estimates it at "at least one instance in every six." The subject of impotence is first considered, being introduced by an account of the physiology of erection. Impotence is divided into four classes: Atonic, psychical,

symptomatic, and organic. Amongst these the author's experience accords an overwhelming preponderance to the first class, viz.: Out of 153 cases, 149 atonic, 1 psychical, 1 symptomatic, 2 organic. The pathological condition most frequently met with is hyperæsthesia, or subacute inflammation of the prostatic urethra. Masturbation is assigned as the chief etiological factor, and an interesting account of its effects is given. Sterility, spermatorrhœa, and prostatorrhœa are afterwards ably discussed; and we cheerfully accord the author full credit for the scientific spirit and method displayed, as well as for patient learning and research; but on the whole we feel bound to place the book in the category of little needed works, whose perusal fails to establish clearly a satisfactory *raison d'être*.

*A System of Surgery, Theoretical and Practical, in Treatises, by various Authors.* Edited by T. HOLMES, M.A., Cantab. First American from Second English Edition. Thoroughly Revised and much Enlarged by JOHN H. PACKARD, A.M., M.D., of Philadelphia, assisted by a large corps of the most eminent American Surgeons. In 3 Vols., with many Illustrations. Philadelphia: H. C. Lea's, Son & Co. Toronto: Hart & Co., 1881.

Holme's System of Surgery is too well known the whole world over to need commendation at the Reviewer's hands. But the English Edition, in Five Volumes, was a formidable and expensive work; and in the ten years which have elapsed since its appearance, the rapid progress of science had made it, in some respects, already old. It is a subject for congratulation, therefore, that the idea of an American Edition, incorporating all recently acquired knowledge and experience, should have been conceived, and its execution entrusted to such able hands as Packard's. The Second English Edition is shorn of none of its merits or its beauties being reproduced entire, the additions and emendations made by the revising editors being interpolated, within brackets, in the text. The names of Simes, Roberts, Longstreth, Conner, Morton, Ashurst, Stinson, Hunt, Jewell, Bartholow, Hodgen, and Packard's other coadjutors, in the edition of the 1st Volume which has come to hand, and



treats of General Pathology, Morbid Processes, Injuries in General, Complications of Injuries, and Injuries of Regions, afford a sufficient guarantee that the work has not only been brought fully up to date, but also that it has been accomplished in that same large, thorough and scientific spirit, which characterized the contributions to the original edition. It would manifestly be impossible, within the limits of our space, to criticize the separate articles in detail; but we gladly bear testimony to the fact that the American Revisers have not sought self-prominence by making unnecessary additions or captious emendations. The half-Russia binding makes a most handsome book. Messrs. Hart & Co., of King Street West, are Sole Agents for Ontario.

### Meetings of Medical Societies.

#### UNION MEETING OF NEWCASTLE AND TRENT MEDICAL ASSOCIATION WITH QUINTE AND CATARAQUI MEDICAL ASSOCIATION.

Both the above Associations held a joint meeting at Napanee, on 5th October. The Quinte and Cataraqui Association adopted a constitution, and the Newcastle and Trent passed minutes of last meeting at Campbellford, when the two associations went into joint session, with the following practitioners present: Drs. Platt, Wright, Evans, jun., Picton; Drs. Burdett, Eakins, Belleville; Dr. Bowerman, Bloomfield; Dr. Hamilton, Port Hope; Drs. Leonard, Ward, Ruttan, Bristol, Cowan, Clark, Edwards, Brown, Napanee; Drs. M. Lavelle, C. H. Lavelle, Metcalfe (Rockwood Asylum), Henderson, Oliver, Kingston; Dr. Beeman, Centreville; Drs. Day, McLellan, Trenton; Dr. W. A. Lavelle, Newburgh; Drs. Beeman, Meacham, Odessa; Dr. Riddle, Baltimore; Dr. Knight, Tamworth; Dr. Clinton, Millpoint. Dr. Bredin, Milford, telegraphed regrets at inability to attend.

Dr. M. Lavelle was called to the chair, and Dr. HAMILTON made Secretary. Dr. Ruttan reported a case of

#### BRIGHT'S DISEASE.

Mrs. —, aged 64, had œdema of limbs for

some time, but whether albuminuria was present at first or not is unknown, but is suspected. She is anæmic. About six weeks ago she had diphtheria, when the boiled urine became almost solid from albumen. Under the use of tinct. ferri perchlor., muriate of ammonia, and steam baths, the albuminuria had nearly wholly disappeared, as did the œdema. Lately she has had a relapse. There is some emaciation. The urine has sp. gr. of 1020. The presence of albumen in abundance was demonstrated. Casts had been found.

#### POST PARTUM HEMORRHAGE.

Dr. M. I. Beeman, Centreville, read a short practical paper, giving his treatment and experience of flooding after labor as managed by hot water injections. He had injected it as hot as about 110° to 115° F., judging by sensation of heat to his own hand, or about as hot as could be borne. He had resorted to it three times, and felt confident reliance in it. Thus, J. H., aged 30, multipara, natural labor, the placenta removed and binder applied. In half an hour she bled profusely. He gave plumbi acet., and applied continuous cold. The flow still being too free a pint of hot water was injected controlling it at once. Fifteen months after he attended the same case, finding child born on arrival, and placenta in vagina. He gave ergot and lead, but had again to resort to the water. P. H., Multipara, had been in labor many hours: forceps delivery. Shortly after removing placenta flooding began. Again gave lead, and sent for syringe. Hot water stopped it instantly. Her recovery was good, although there was evidence of some irritation. He would prefer it to either the internal or external application of cold. External cold, if used, he would prefer the ether spray.

Dr. Ruttan thought retention of part of placenta was the most usual cause of flooding. He thoroughly removed placenta, and after that had not found it necessary to resort to anything beyond usual remedies, not even lead. He had however given a drachm of lead acetate in hemoptysis. He had used perchloride of iron locally in post-partum hemorrhage, not in solution but dry. He carried as much as a nasal polypus forceps would grasp of the dry salt up to the fundus, and opening the forceps allowed it to be

there deposited. It produced firm contraction immediately, and had the advantage of leaving the cervix open. If the pulse falls after labor there will be no hemorrhage. If the pulse runs high we should not leave the patient.

The Chairman, being called on, stated that he had lost but two cases from hemorrhage immediately after the child was born and before delivery of placenta. He thought it was the sudden cases which were fatal. He had no experience with hot water. He gave a 3i. dose of fluid ext. ergot when the head appeared at the vulva and if no response another dose. He brings away the placenta as soon as detached. He was decidedly in favor of plumbi ac. in 3ss—i. doses, where ergot fails. He gave it in either solution or powder using the pure crystals kept in well stoppered bottles, and no other. He has given 3ss. every four hours for 48 hours. He had never known it to fail. True, it might produce vomiting and even violent diarrhoea, but it still has its specific effect on uterus. It acts through the sympathetic system on involuntary fibre. Its promptness was remarkable. We must have complete condensation of uterine tissue before we have the hemorrhage completely controlled. He thought the inward application of cold improper, except by insertion of a piece of ice. He would condemn the injection of solution of perchloride of iron. He had seen serious results from it and other astringent injections. He had relied on lead too in hæmorrhage from the bowels in [typhoid?] fever.

Dr. Platt believed that pressure upon the pudic nerves, where they crossed the ascending rami of ischia, would cause contraction of the uterus and expulsion of placenta, and could be utilized in flooding. He would expect much from the procedure known as "knuckling the uterus." What he had seen in consultation was not in favor of the use of perchloride of iron. The chief objection was the prolonged suffering it caused the patient.

On experience with the hypodermic use of ergot being asked for, Dr. Oliver reported favourable effects from its use in hemoptysis.

Dr. Bristol had seen but one fatal case. He preferred to rely on stimulating the uterus to contract by introducing the hand, which was more reliable than ergot.

A vote of thanks was tendered Dr. Beeman for his paper.

Dr. Day opened the subject: "The Relation of the Medical Council to the Profession," which led to a pretty general discussion, as to the doings of the Council, and the interest of the profession therein. Five or six members of the Council resided within the district.

Dr. M. Lavelle gave an historical retrospect of the constitution of the Council, and some difficulties it had to meet. It was considered best to take no immediate action in the matter, but having opened it now to more fully ventilate it at the next meeting of the Association.

The annual fees, increased territorial representation, cost of holding the Council's examination, the utility of a proposed museum, the purchase of the Council's hall, its debt, and the proposal to hold the University of Toronto examination in lieu of that of the Council, as the University has the confidence of the country, is supported by it, and is not a teaching body as regards medicine, but only an examining one. All of these were discussed, and brought out opinions *pro* and *con*.

#### TORTICOLLIS.

Dr. Ward presented a plumber and tinsmith, aged 32, who had been exposed to cold, after which he began to complain last January of pain in the back, which was called lumbago. Soon it was noticed that his head was turned to the left side. There is no spasm during sleep. He has had a chair made with head-rest, in which he was presented. The sterno-cleido-mastoid of the right side is notably hypertrophied. When left to himself spasm is moderate, but in presence of several, as at time of presentation, the amount of spasmodic contortion is almost painful to witness. He had been in the hands of both regulars and quacks. A regular had cupped and blistered, after which he was worse. Later, the same practitioner had given quinine, which was of apparent benefit. Later still he came under the care of Dr. Hammond, of New York, whose treatment Dr. Ward was still carrying out under Dr. H.'s supervision. He was given one half to two grains of bromide of zinc, combined with 20 to 40 grains of bromide of sodium three times a day, and hypodermic injec-



tions of atropia, once a day. The Faradaic current was applied to the left sterno-cleido-mastoid. Benefit was also derived from the direct galvanic current applied to the muscle affected with spasm. About the 20th of July there was great improvement, at the time an eruption appeared on face and chest, believed to be due to the atropia. His general condition requiring it, he was, with Dr. H.'s consent, put on quinine and iron, but grew worse, when the former treatment was resumed. About 1st of September, the muscles of the neck, back, and even the groin and left leg, became affected.

## DINNER

Was had at the Campbell House, where an abundant and sumptuous repast had been prepared for all present, by the resident practitioners in Napanee.

After this, Dr. Ruttan took the chair, when Dr. Hamilton gave his method of treating

## EPISTAXIS,

Which was to treat the matter surgically and mechanically, rather than by local medications, which were irritating, disagreeable, and apt to be unsatisfactory in result. As to general treatment, ergot and sulphate of soda were mentioned. Of local treatment, main reliance was to be placed on arterial compression made upon both superior and inferior maxillary bones. This could be readily and safely done by any only half-intelligent nurse, as occasion might arise. Even in prolonged cases it was hardly conceivable that it should be insufficient until the arrival of the surgeon. So far, since adopting this plan, he had found it all-sufficient. In more serious cases, plugging the posterior nares might have to be resorted to. Few of us have a Bellocq's canula, considered the *ne plus ultra* instrument for this. The posterior nares could be plugged, however, readily, by tying a small plug of styptic cotton with string, which was to be threaded through a eustachian catheter, by means of wire, and then by aid of the catheter from before backwards, placed *in situ*, with thread protruding from the nostril. A second, or even third small plug was to succeed the first if need be. Lastly, a plug in front made all secure. A piece of sheep's intestine, as Gross suggested, or that of fowl, might be

tied at one end and inserted; and then either inflated with air, or filled with water. So might a toy balloon. He had been compelled to resort to plugging before learning the compression "wrinkle," not since.

Dr. Oliver had used rather fine stove-pipe wire, bent double and inserted through the nostril as a substitute for Bellocq's canula. The end, on impinging against posterior wall of pharynx, would bend down around the soft palate, until the cord the wire carried could be reached by way of the mouth. This cord was then made the means of drawing a plug into the posterior nares in the usual way.

Dr. Ruttan had succeeded by throwing cold water behind the soft palate with a syringe, and allowing it to flow forward. This was to be repeated as often as necessary.

Dr. Metcalf had used astringents thrown in like manner by an ordinary enema.

Dr. Brown reported a case of complete

## INVERSION OF UTERUS.

The case was that of a woman delivered of her fourth child, after which there presented what gave the impression of being an enormous placenta, slowly impelled outward by expulsive efforts. Soon the afterbirth was expelled, and was quite large. A large part of the protruding mass was then found to be the uterine body in a state of complete inversion. He, on examination, considered it such, gave an opiate, and called a consultation, when, by means of pressure, steadily exerted by soft cloths, success crowned efforts at replacement. The vagina was then plugged to prevent possible recurrence. The recovery was good.

## ADJOURNMENT.

The Q. and C. Association then adjourned to meet at Belleville, on first of February, and extended an invitation to their sister N. and T. Association to hold a joint meeting again (at Belleville), which was accepted.

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MCGILL MEDICAL SOCIETY.—At the annual meeting, held October 8th, the following were elected: President, Dr. Molson; 1st Vice-President, Mr. Duncan; 2nd Vice-President, Mr. Shaw; Secretary, Mr. Loring; Treasurer, Dr. Gardner; Librarian, Mr. Cameron; Council, Dr. Buller, Messrs. Smith, and Gooding.

## REPORT OF THE TORONTO MEDICAL SOCIETY.

The Society met on July 14th, the President in the chair. The minutes of the last meeting were read and approved. Dr. Sheard exhibited a specimen of aneurysm of the abdominal aorta, also the heart from the same case, weight nineteen ounces; it was hypertrophied and dilated, with vegetations on the aortic and mitral valves, and atheroma of the aortic arch. The patient from whom this specimen was taken was syphilitic, the kidneys were congested, and the liver nutmeg. The same gentleman also exhibited a portion of the lower end of a femur, which showed a spiculum of bone projecting from the internal condyloid ridge, just where the femoral artery passes into the popliteal space. There had also existed in the same case an aneurysm of the popliteal artery, supposed to have been brought about by the artery having been punctured by the spiculum of bone.

The discussion of Dr. Graham's paper on Leucocythæmia was then taken up, which partook of a conversational form.

Dr. J. S. King was then elected a member of the society.

Dr. Workman then read a paper upon "Animal Magnetism." He spoke of the functions which the various nervous systems played in the hypnotised person. He gave the methods of inducing and relieving hypnotism, and spoke of its relation to hysteria. He mentioned some very interesting experiments, as performed by Charcot and others, and spoke of the effect of hypnotism upon the senses, its application to surgery in place of ether and chloroform was not successful. He also related some of the phenomena produced by suggestion in the hypnotised person.

The Society met on the 22nd September, the President in the chair. After the reading of the minutes, Dr. Sheard exhibited a liver in which there existed two large hydatid cysts, the right one the larger of the two, communicated with the duodenum. The patient, prior to her death had been passing hydatids by the bowels. In the same patient, in the region of the right ovary there existed an independent cyst, having no communication with the other

cysts in the liver or any of the viscera. It contained hydatids in its interior.

Dr. Nevitt then showed a fleshy mole; it was a perfect cast of the uterus, and consisted of fibrine. There was no muscular tissue in its composition.

Dr. Nevitt then read a paper upon Pertussis. He related the history of the disease and the derivation of the name, he thought it to be one of the most contagious and fatal of diseases, and referred to the early age at which the disease may occur. He referred to a case in his own practice where the disease showed itself shortly after birth. He thought there existed a distinct ratio between the prodromic stage of the disease and the disease itself. He gave instances where death occurred from complications. The treatment is by the administration of belladonna, chlorate of potash, chloral hydrate, and quinine, with the exhibition of inhalations and maintaining the strength.

Drs. Workman, Covernton, Canniff, and others, took part in the discussion upon the paper.

Dr. Oldright mentioned a case of atrophy of the scapular muscles, in which he ordered tonics and electricity; and also of incontinence of urine, where the administration of belladonna to its full effect had failed to prove serviceable.

Dr. Geo. Wright mentioned a case of chancre of the lip, in which the patient neglected the treatment ordered, and secondary symptoms showed themselves.

Dr. Cameron referred to a case of lacerated wound of the face, from the kick of a horse; also an extensive saw-wound of the hand, where primary union had taken place under the lead and spirit lotion dressing.

Dr. Macdonald mentioned a case of parturition in which there was complete rupture of the perineum extending into the rectum, which united without any surgical interference.

Dr. Canniff having resigned his position on the active staff of the Toronto General Hospital, Dr. J. H. Burns has been appointed in his place.

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## Births, Marriages and Deaths.

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### MARRIAGE.

On the 4th inst., at Montreal, Henry Yarwood Baldwin, Esq., M.D., C.M., to Adele Gertrude Mary Pinsoneault, youngest daughter of the late Alfred Pinsoneault, Esq.

### DEATH.

In Galt, on Thursday, the 13th inst., Agnes C. Graham, beloved wife of Dr. J. P. Brown, aged 30 years.



# THE Canadian Journal of Medical Science.

A MONTHLY JOURNAL OF MEDICAL SCIENCE, CRITICISM, AND NEWS.

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TORONTO, DECEMBER, 1881.

## Original Communications.

### PUERPERAL ECLAMPSIA.

BY L. MCFARLANE, M.B.,

Adjunct Lecturer on, and Demonstrator of, Anatomy in  
Toronto School of Medicine.

Some time ago I sent you a report of three cases of puerperal eclampsia treated by the subcutaneous injection of morphine. I then expressed my firm belief in the efficacy of the treatment adopted. I have since had two cases similarly treated, with like good results.

The treatment of eclampsia is as interesting a topic as any in the whole circle of our art, as it is a common and fatal disease. The various systems of treatment adopted from time to time have been anything but satisfactory, although nearly every drug in the whole range of the Pharmacopœia has been tried. It is unnecessary for me to enumerate the different remedies used and the results obtained, as they are perfectly familiar to the reading student and the active practitioner—suffice it to say that each has had its advocates although the results obtained have been far from satisfactory.

The lancet is still held by some practitioners as the sovereign remedy in this disease. But as to its uniform or general benefit I am very doubtful—there is nothing in the nature of the case, or in the apparent condition of the patient to justify its use. Not a few practitioners conjoin active purging with venesection, or trust to it alone. Some have great confidence in chloroform and ether, others in emetics, others in chloral hydrate and the bromides, while I believe from reading the *Canadian Journal of Medical Science*, there is one individual whose

faith is strong in the efficacy of ten grain doses of quinine every two hours, although he has failed to inform the reader how it was administered.

There has of late years been an endeavour on the part of the leading minds in our profession, to treat the disease on a pathological basis. This is to be highly commended and I hope the investigation will be pursued till a fixed pathological basis is found upon which we can confidently rest our treatment.

After all that has been written on the subject, I do not think there is a tittle of evidence to prove that disease of the kidneys has anything to do with the production of eclampsia. save as a casual companion or possibly a favouring condition. It is quite as likely that the condition of system giving rise to eclampsia may be the exciting or predisposing cause of the disease of the kidneys. Cases must have come under the observation of every practitioner doing a large midwifery practice of patients having almost complete anuria without any sign of convulsions. And it is a matter of everyday occurrence to meet with cases where the urine is loaded with albumen, and the limbs and body dropsical without any appearance of eclampsia. Now if the diseased condition of the kidneys is the cause of convulsions as claimed by some pathologists, why should so many escape who are suffering from it. It would be supposed that the same cause would produce the same effect in all cases. It is a well-known fact that ague is always produced by the same malarial poison, and that the person whose system becomes saturated with it will necessarily get the disease. The same remarks will apply to typhoid fever,

tubercle, syphilis, and, in fact, to every disease affecting the human system, each has its specific cause and none can be produced by any other but the specific poison.

It must be admitted, however, that in many cases, we are unable by any means at our command, to discover the pathological condition upon which it depends. But this is no argument against its existence. For the particular disease under consideration the pregnant condition is necessary to its production, and consequently it will be well for us to consider, in a practical way, some of the leading features in connection with this condition. In the first place the system will be burdened with the extra work of supplying and developing the fœtus. The heart will necessarily have more work to perform in carrying on the fœtal as well as the general circulation. The nervous system will also have extra duties in contributing to the development going on.

Now in order to have a healthy body it is necessary to have the circulatory and nervous systems in a healthy state. If either, or both, are disturbed from any cause, the effect is soon felt on the general system. It is only necessary to notice the effect of fear on the human system to illustrate this fact. Look at the expression of countenance, the nervous tremor, the disturbed digestion, and sometimes the involuntary evacuation of urine. If fear has such a marked effect upon the system is it not reasonable to suppose that the over-taxing of the nervous and circulatory systems will produce not only eclampsia, but disease of the kidneys. It is evident that the fœtus in utero acts as a quasi foreign body, inasmuch as it serves as a source of irritation from the very commencement of gestation. The patient almost immediately after conception is disturbed by nausea and vomiting, which sometimes defy our best efforts to suppress. The labour required of the circulatory and nervous systems increases as gestation advances. Consequently at or near the termination, the nervous centres are worked up to such a state of tension, if I may so express myself, as to relieve themselves by that spasmodic condition called convulsions. This, I believe, is substantially all we know, or at least, by far the most we know about the

etiology of eclampsia. It is an explanation, I grant, somewhat vague and general; but in the absence of any other more exact, or to the point, I am inclined to accept it.

Before entering on an explanation of the treatment allow me to give a brief report of the two cases before mentioned:—

Case I.—Mrs. G—, aged 26, Primipara, was taken in labour about one a.m. on the 4th of February. I was sent for about nine a.m., and found the head presenting, and the labour well advanced in the second stage. The child was born about one hour after my arrival. I removed the placenta, made my patient as comfortable as possible, and remained in the house for half an hour or more. On leaving she expressed herself as feeling very well. In about one hour afterwards I was sent for in great haste, and on my arrival found my patient working in a convulsion. The nurse informed me that she had three fits before I got there. I at once administered one quarter of a grain of sulphate of morphia subcutaneously, which controlled the convulsions, the patient falling into a quiet sleep which lasted for several hours. In the evening of the same day the nurse was removing some of the soiled clothing when the patient attempted to sit up and was seized with a slight convulsion, which was almost immediately controlled by a second injection of  $\frac{1}{4}$  grain of morphine. After this she went on to convalescence without any further symptoms of eclampsia.

Case II.—Mrs. T—, aged about 30, pregnant with her third child, was seized with convulsions at the commencement of labour, Drs. Winstanley and Richardson chloroformed the patient, dilated the os, and delivered with forceps. The fits continued at regular intervals from some time in the night till the following afternoon, notwithstanding the use of chloroform and chloral hydrate. I saw her about three p.m., when a quarter of a grain of morphine was administered, after which the convulsions ceased for three hours. She then had a slight convulsion, when I again administered a second injection of  $\frac{1}{4}$  of a grain of morphine, which completely controlled the eclampsia. The patient going on to convalescence without any further trouble.



I will now briefly give my reasons for the use of morphine in the treatment of this disease.

I before intimated that the increased labour required of the heart in carrying on the foetal circulation might disturb the general circulation, and as a consequence anæmia of the brain be produced. In the second place the brain and the nerves of organic vitality become irritated and exhausted by the duties required of them.

The question might be here asked if this theory is correct, why do not all pregnant women suffer from eclampsia. The only answer I can give to this query is that some women bear their pregnancy more lightly than others, and that there is not so much disturbance of the nervous and circulatory systems.

However, if this theory is correct, as I am inclined to think, we have two indications for the use of morphine. In the first place, by giving this drug we produce an increased flow of blood to the nerve centres, and in the second place, by its soporific effect the brain is allowed to rest while increased power is gained to carry on the nervous functions of the body. The control which morphine exercises over the disease, both in the preliminary stage as well as when the convulsions actually set in, is so prompt and decisive as to convince the most sceptical after having given it a fair trial. No doubt in some cases, from the violence of the attack or the injury done to the brain by the first onslaught of the convulsions, the medicine will fail; but I am fully convinced that if properly administered and in time, we have in our hands a sure and certain remedy for this disease.

I believe that many of the failures reported after its use can be accounted for by the mode in which it is administered. To give any preparation of opium in this disease by the stomach is of little, if any, use, as the sickly condition of the organ is such that the medicine is not absorbed in time to be of any benefit to the patient. And no man should venture an opinion as to the virtues of the drug unless he has given it subcutaneously. I am satisfied that in the two cases before mentioned the dose used was not sufficiently large. If half a

grain or a grain had been used at the first injection the probabilities are that a second fit would not have occurred. I would, therefore, advise at least half a grain at the first dose.

There need be no fear in administering large doses of morphine in this disease as the system appears to tolerate large quantities of it. I am satisfied that you can give doses with safety in eclampsia, that would prove fatal in any other form of disease.

However, every indication can be met, by giving from one half to one grain at an injection. And I venture to say if this quantity is given there will not likely be any necessity for a repetition.

The point to note in giving the drug is to give it early, and in sufficiently large doses to control the convulsions.

The necessity of hastening the labour should not be neglected or overlooked, as I consider the sooner the delivery takes place the better is the chance for the recovery of the patient, as you remove the main source of irritation.

In conclusion allow me to urge on those of my readers who have not yet tried the drug to avail themselves of the first opportunity to put it in practice. And I feel confident that after giving it a fair trial they will agree with me that it is the sovereign remedy in this disease.

## CASES IN PRACTICE.

BY E. JENNINGS, M.D., HALIFAX.

[Read at the meeting of the Canada Medical Association, Halifax, August 4th, 1881.]

[The object of Dr. Jennings, who read the report of the following cases, was to show the effect of constant irrigation of wounds with carbolyzed water, as compared with the ordinary Listerian spray and gauze.]

Alexander Griswold, aged 50, cut his throat on May 13th, in a fit of insanity, and was admitted to the hospital same night. When examined there was found to be a large clean cut wound on the right side of the neck, extending from the posterior border of the sterno-mastoid, to the inferior border of the inferior maxillary bone. The wound is two inches deep posteriorly, the sterno-mastoid being completely cut through, and the carotid artery exposed,

but not injured. The wound is gaping widely and looks as if it could contain a moderate-sized hen's egg. There was no hæmorrhage when he was admitted.

May 14th, Dr. Jennings stitched up the wound to-day, the edges being everted. A drainage tube was then passed through and a bottle suspended above the wound, being filled with 1 in 60 solution of carbolic acid. A wick was led from it through the drainage tube, coming out of the lower end. The solution passed along the wick, by capillary attraction. The wound being in this manner kept constantly moist with carbolic acid. The solution as it ran out of the tube was caught in a basin. A yoke was then put on the patient to prevent any motion of the head, whether lateral or nodding, etc. The patient seems to suffer no pain, and there is no febrile disturbance.

May 15th.—The fluid in the basin which had run through the drainage tube was to-day examined by the microscope, but no pus corpuscles were found. Patient seems comfortable. Wound healthy.

R Acid. Nitrici. dil. . . . . ʒiij.  
Tinct. Calumbæ . . . . . ʒiv.  
Inf. Gentianæ ad. . . . . ʒvj.  
Misce et fiat mistura.

Signate. ʒss. ter in die capiat.

Et. R Pil. Rhei co. No. xxiv.

Sig. One every night.

Ordered to have full diet. Port wine ʒiv daily.

May 21st.—The fluid in the basin has been examined every day since the 15th, but no pus has been found.

May 22nd.—Last night, through some carelessness, the carbolic solution ceased to run through the drainage tube, the bottle having been allowed to get empty, and to-day there was a moderate amount of pus around the wound. The yoke was then taken off and a dressing of Peruvian balsam applied.

May 30th.—The wound is almost healed, surface granulating finely and looking very healthy. He is now out of bed and moves about the ward. His appetite is good. Bowels not so sluggish as before. There has been no febrile movement throughout the treatment. His temperature on no occasion being

above normal. He suffers no pain in the wound now, and has not had any pain since admission.

June 4th.—Wound has now completely healed, and the patient wishes to go home, being in his usual health. He was accordingly discharged, after having been in only twenty-two days—May 13th to June 4th.

July 4th.—The patient was heard of a few days ago. He was then in excellent health and engaged in his regular occupation.

Case II.—AMPUTATION OF THIGH.—John Yates, aged 11, admitted to the City Hospital June 10th, 1879, under the care of Dr. Jennings, attending surgeon.

History.—On Feb. 10th, 1879, he fell a distance of 110 feet down the shaft of a gold mine, striking against pieces of timber placed across the shaft, in his descent, and finally falling into a pool of water at its bottom.

He was taken up, and a physician summoned, who found that the patient suffered from fracture of the left arm and thigh, which he set, but whether he discovered fracture of the right thigh or not could not be ascertained. He, however, bandaged the right leg tightly from the foot upwards, and not returning, the patient's friends, on the third day after the accident, removed the bandage to relieve him from the pain which it caused. It was then found that the foot had become gangrenous. After this the condition of the patient grew steadily worse, and finally it was decided to bring him to the hospital.

Condition when admitted.—Much emaciated, arm and thigh of left side united satisfactorily. Foot of right leg sloughed off, being retained by a small portion of integument; the remainder of the leg much swollen and thigh honey-combed with sinuses, particularly near the hip-joint.

A consultation of the staff decided that the only thing practicable was amputation at or near the hip-joint. The general condition of the patient was extremely unfavourable, the pulse being so rapid and weak as to be almost impossible to count. He was given milk, beef tea, with alcoholic stimuli, and at six o'clock of the same day was removed to the operating room, and put under the influence of ether. Esmarch's bandage was applied, and the



tourniquet placed over the femoral artery and vein, which before the operation were cut down upon, and tied. The ordinary flaps for amputation at the hip-joint were made, and it was found that the patient had been suffering from extra-capsular fracture, that the bones had not united, and that the sinuses above mentioned led down to the fractured ends. The femur was sawn through above the trochanters; all the bleeding vessels secured, and the flaps brought together by means of silk sutures, ample provision being made for free drainage of discharge. During the operation the utmost care was taken to prevent loss of blood, and in this the surgeon was almost perfectly successful, as scarcely any hæmorrhage occurred.

*After treatment.*—Patient was removed to his ward; stimulants and supporting diet ordered. The temperature which, before the operation, was 100° F., fell to 98° F. The pulse was still very frequent. Had no opiate, but slept well during the night.

June 11. An evaporating lotion of muriate of ammonia, gr. xl. to ʒi., was applied to the stump by means of the irrigation apparatus. Pulse 160, temperature 102° F. Symptoms of diarrhœa set in, for which he was ordered R. Mist Amyli. ʒi; Tr. opii. ʒi. Sig. A teaspoonful to be injected into the bowels as required.

June 12. Condition much the same. Pulse 144; temperature 100°. Ordered two tea spoonsful, three times daily, of elixir of beef iron, and wine.

June 13. Complains of sleeplessness. Ordered. R. Sol. mur. morph. mxx., quiniæ sulph. gr. ij.; syrup simp. ʒij.; aq. ad. ʒij. Sig. At once.

June 14. Irrigation was removed. Also the strips of adhesive plaster which supported the sutures holding the flaps. It was now found that the greater part of the line of union of the flaps had united by first intention. Carbolic oil 1 in 8, was injected into the wound through the drainage tube placed between the flaps. A bed sore was discovered over the sacrum, which was dressed with carbolic oil, and patient ordered to be placed on a water bed. Remaining sutures were removed on the 20th, and the drainage tube on the 22nd. From this time the patient rapidly recovered, and was discharged well, Aug. 7th, 1879 twenty-seven days after operation.

## A CASE OF QUININE RASH.

BY L. M. SWEETNAM, M.D., C.M.

P. K., æt. 24, born in Ireland, machinist (having worked at the lathe, turning iron, for eight years). Emigrated twelve months ago. Has been in Toronto General Hospital for eleven months, during which time he has been treated for phthisis.

In September of this year went out of the hospital for two weeks, and about a week after returning, developed symptoms of typhoid fever, for which the following mixture was prescribed: Quin. Sulph., ʒss., Acid Sulph., dil., ʒij., Syr. Zingiberia, ʒij., Aq. ad ʒviii., Sig. ʒss., t.i.d. Had been taking this mixture for three weeks without any discomfort, when it was found necessary to resort to stimulants; whisky was then ordered.

About fifteen minutes after taking the first dose (ʒi.) he complained of a smothering sensation, and difficulty in breathing, discomfort in cardiac region, to which were shortly added a feeling of fulness in the head, congestion of conjunctivæ, nausea, dryness of throat and fauces. On examination the mucous membrane of buccal cavity was of a deep red colour; in about five minutes after these symptoms set in, he complained of a burning and itching sensation in the palms of his hands and soles of his feet; red spots then appeared on the palms of his hands, and spread up his arms; similar spots then appeared on his forehead, and simultaneously upon his chest. These spots, or patches, increased in size, and uniting, covered nearly the entire surface of his body, which was then of a dark red measles colour on the face, and a bright scarlatina red elsewhere, the upper fourth of the inner aspect of the thigh, and some irregular patches on the inner side of his arms and feet, alone retaining their natural colour.

The patient complained of being chilly during the early part of the attack, he then complained of heat, with a burning sensation of the skin. As the eruption became more general, and after it had subsided, he perspired freely.

The eruption, which at first might be mistaken for urticaria, later resembles an erythema,

and is at its height in half-an-hour. During the time that the eruption is fading the line of demarcation is fairly well marked, but less so than it is while spreading.

While this was a quinine rash, the stimulus derived from the whisky appeared to be essential to its production, and now that he is becoming accustomed to the whisky, a larger amount is required to produce the eruption. Tr. Cinchona Co. has since been ordered for him, and while taking this form of the drug the whisky fails to produce the rash.

### COMPOUND DISLOCATION BACKWARDS OF THE TERMINAL PHALANX OF THE THUMB.

BY FRANCIS J. SHEPHERD, M.D., C.M., M.R.C.S. ENG.  
Demonstrator of Anatomy, McGill University.

This form of dislocation of the thumb is when simple not very rare; it is not quite so commonly seen when compound, still it falls to the lot of every surgeon to see one or more cases. Many surgeons advise amputation in all compound dislocations of the phalanges, others prefer resection of the joint, while others again affirm that they have the best results by simply reducing the dislocation by extension or manipulation, and after reduction placing the digit in a splint and using evaporating lotions. Each case, however, must be treated on its merits. In the case I am about to relate I amputated the phalanx for several reasons, viz.: On account of the state of the joint, the age of the patient, the length of time that had elapsed since the accident, and last, but not least, because I have seen just such injuries, when left alone, end in tetanus.

Chas. Garrod, labourer, aged 68, came to the Montreal General Hospital, July 11th, 1881, complaining of a sore thumb. He said that five days ago he had slipped and fallen, and in trying to save himself had thrown out his right hand and had hurt his thumb; that as the thumb was not very painful at the time he did not bother much about it or consult a doctor. Now it was becoming painful, and as he was passing the hospital he thought he would come in and see what could be done for him. On examination I found that the terminal phalanx

was dislocated backwards, and the distal end of the first phalanx protruded through a wound which extended completely across the palmar surface of the thumb. The flexor tendon could not be seen through the wound. The thumb was much swollen, red and inflamed, and a small amount of foetid pus was being discharged from the wound. As the man was old, the joint suppurating, and the result of excision doubtful, it was thought better to amputate the last phalanx. This was done, the flap being taken from the dorsal surface, and the protruding end of the first phalanx cut off. A pocket of pus was found at the back of the joint, and the flexor tendon was seen completely torn across. The wound healed without a bad symptom in ten days. It was very remarkable how little trouble such a condition of affairs gave the old man. He did not cease from work, and only came to the hospital because he happened to be in the neighbourhood, and it was with difficulty I could persuade him to allow me to remove the phalanx, for, as he thought, so trifling an injury.

### GUNSHOT WOUND OF ABDOMEN.

J. H. GARDINER, M.D., LONDON EAST.

Peter Lappan, æt. 40 years, was on the morning of the 20th August wounded by a revolver shot. (Weight of ball 3ss.) He was in the act of drinking a glass of ale, or as he termed it an appetizer for breakfast, not having had anything to eat previously. I saw him about twenty minutes after the accident. He was very pale, and had vomited once or twice. Pulse 80, very feeble. Thinking him in extremis, I decided to wait until my partner, Dr. Street, arrived, whom I had telephoned for on receipt of message, before making a thorough examination. In the meantime I gave him an ounce of brandy and water, which he vomited. On the arrival of Dr. S. we examined the wound. The ball entered the epigastrium, a quarter of an inch below the ensiform cartilage, and half an inch to the right of the median line. We followed the course of the ball about three inches, until the cavity of the abdomen was entered. Thinking it unsafe to proceed further at this time, we desisted. At one p.m.



we again saw patient, and had him removed to General Hospital, where he was given a hypodermic of a quarter of a grain of morphia. Upon careful examination we detected a slight tumour two inches from the spine of the vertebrae, between the eleventh and twelfth ribs. This, Dr. S. cut down upon, and to our pleasure found the ball resting against the lower edge of the eleventh rib, two inches from the surface. This we extracted. The liver dullness extended an inch and a half to the left of the wound in front, and it can be felt at the edge of the ribs. Hence the liver must have been wounded.

The temperature never rose above 101° F. He was kept on light diet for ten days, with, for the first five days, a little morphia at bed time. No stomach trouble showed itself after twenty-four hours; and only a slight jaundiced tint was at any time observed.

To-day he was in my office, not very strong, it is true, but well enough to be around. He still complains of a slight tenderness over the liver, and a feeling as if a cord were tied through him.

No injections were at any time used, and only water dressings at first, followed in a few days with carbolized oil.

This following, as it did, the famous Garfield case, is the only reason I have for trespassing on your space.

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Gruber discusses the significance of the habit of some deaf patients of keeping the mouth open. 1. He thinks it highly probable that certain deaf people who are annoyed by loud respiratory noises produced in the nose hear better by opening the mouth; but that it can not be asserted that these respiratory noises are the sole reason why deaf persons keep the mouth open in listening. 2. The perceptible improvement in hearing gained by keeping the mouth open is in many patients due to the changes in the external auditory canal and deeper structures of the sound-conducting apparatus produced by sinking of the lower jaw. 3. In many of these patients the hearing power is improved by the change in resonance produced by the condition of the mouth. 4. The facilitation of the respiratory act which is produced by the opening of the mouth would probably aid in improving the hearing power.—*N. Y. Medical Journal.*

## Selections: Medicine.

### ANTISEPTIC INHALATION IN PULMONARY AFFECTIONS.

Read Before the Southern Branch, B. M. A.

BY J. G. SINCLAIR COGHILL, M.D., F.R.C.P.ED.

Physician to the Royal National Hospital for Consumption.

THAT the comparative accessibility, of the lungs, through the glottis, should have, even in the earliest times, suggested direct medication, is not surprising; but it is, indeed, strange that inhalation, or taking advantage of the respiratory act for this purpose, which dates from the days of the Father of Medicine himself, should only have received, until comparatively recent times, but occasional and rare employment. That its importance was from time to time recognised, there is abundant evidence in the works of the older physicians; and, that this importance was even occasionally exaggerated by them, is shown by the statement of the celebrated Italian physician, Mascagni, who says: "If ever a specific should be devised against consumption, it would be such as to be introduced into the organism through the windpipe." A succession of celebrated names in more modern times, too numerous to mention, is associated with the subject of pulmonary medication by inhaling; and a great variety of apparatus, more or less elaborate, has been introduced from time to time for the purpose. There are, however, great objections, apart from the almost impossibility of their penetrating deeply enough into the tissue of the lungs, to the inhalation of dry powders, however finely divided, on account of their mechanically irritating effect on the often already morbidly sensitive laryngeal and bronchial surfaces. Non-volatile fluids, again, can only be very partial in their distribution; and, if inhaled at high temperature, must further render the upper reaches of the respiratory tract sodden, and increasingly sensitive to changes of temperature. Careful observation of the action and effects of this steaming process in affections of the lungs has convinced me, that it is not only inefficient, but, in every respect, positively injurious. It relaxes the tissues with

which the vapour comes into contact; it encourages suppuration where the ulcerative process has begun, and it tends, therefore, to increase expectoration and cough, and consequently the distress and exhaustion of the patient. The inhalation of hot moist vapour, indeed, is so repugnant to the respiratory tract, that but a small quantity of the medicated material can penetrate sufficiently into the pulmonary tissue to be of use. The immediately subsequent effects are also not unattended with risk, from the exposure of the air-passages to air of a lower temperature after hot inhalation. However beneficial, then, in laryngeal affections (and we are all familiar enough with its value in such), the inhalation of dry powders, or of pulverised fluids in the form of spray, either cold or hot, may be, they cannot be regarded seriously in connection with the treatment of suppurative processes within the lung itself.

It is now more than five years since I became strongly impressed with the important bearings of Lister's teaching on the local treatment of phthisis; and, in working out the idea of antiseptic inhalation, the considerations above referred to, suggested the plan of adopting the principle of the old-fashioned, and now happily almost obsolete, respirator for the purpose—selecting a volatile medium for the antiseptic materials, and employing the breath in the alternate acts of inspiration and expiration, as their vehicle.

The apparatus is extremely simple. It consists of a space for a pledget of tow or cotton-wool, enclosed between the perforated surface of the respirator and an inner perforated plate, which can be raised so as to permit the tow to be saturated with the antiseptic solution. Elastic loops are attached to pass over the ears, and retain it in position. The inhaler may be procured either plain, or of a slightly-smaller size, and covered with black cloth, for wearing out of doors. The pledget of tow, which may be changed once a week or so, should be sprinkled with from ten to twenty drops of the antiseptic solution, from a drop-stoppered phial, twice-a-day at least, according to the extent to which the inhaling may be carried on. Of this the patient is the best judge, and the length of

time and quantity of solution should be regulated by tolerance and effect. The most important times for inhaling are for an hour or so before going to sleep at night, and after the morning expectoration, which leaves the suppurating surface or cavity dry to be acted upon—disinfected, so to speak—by the antiseptic vapour. A great many of my patients have of their own accord come to use the respirator almost continuously day and night, from their experience of its good effects. I attach the utmost importance to the mode in which the respiration is conducted while inhaling. The patient should be carefully instructed to inspire through the mouth alone, and expire through the nose. In this way, the breath is drawn through the saturated tow in the perforated chamber of the inhaler, and passes directly into the lungs laden with the antiseptic materials. Expiring through the nose only, necessarily involves a complete circulation of the medicated air. The breathing should be short at the beginning of inhalation, but gradually deepened, so as to displace and affect the residual air in the more distant portions of the lungs. This form of respiration itself is not only of great use in favouring the circulation of the blood in the lungs, and thus aiding both local and general nutrition through that fluid, but it helps very much the expulsion of the sputa by means of the increased energy and thoroughness of the expiratory acts. Indeed, the great objection to the ordinary respirator lies in the shallowness and rapidity of breathing which it involves, in consequence of which the lungs, being imperfectly expanded and contracted during each act of respiration, become themselves literally fatigued, and the breath is drawn in and forced out so feebly, and at the same time so quickly, that there is not time for it to be dispersed into the fresh air, but it returns each time into the lungs only partially changed. The extremely fetid odour which the apparatus rapidly acquires is sufficient proof of this. One of the patients in the Royal National Hospital here, when I was working out this subject, made a pasteboard respirator for antiseptic inhalation of such a shape as to include the nose; but it was found to have all the objectionable points of the ordinary respira-



tor, and certainly did not permit sufficiently free access of the medicated air to the lungs, a large amount of the antiseptic material being lost by absorption on the convoluted walls of the tortuous nasal channels.

After many trials of the now formidable list of antiseptics, I find that carbolic acid, creasote, and iodine, in combination with sulphuric ether and rectified spirits of wine, are the most efficacious and satisfactory. The want of volatility in boracic, salicylic, and benzoic acids, and their salts, proves a bar to their employment by this method. Dr. Horace Dobell, who has had a very favourable experience of this treatment, writes to me that he has found thymol, in the form of Shirley's thymoline, very grateful and efficient, in many cases, where the smell of carbolic acid and creasote was intolerable either to patients or to their friends. Of the three antiseptic agents I chiefly use, I find iodine most useful in the second stage of phthisis, when the expectoration is passing from the glairy into the purulent character. I use a tincture, for inhaling purposes, made with sulphuric ether instead of spirits of wine; and this ethereal solution has a singularly soothing effect on the cough and pulmonary irritation. In combination also with carbolic acid as carbolised iodine, or iodized phenol, it is extremely useful in the purulent expectoration accompanying the resolution of pneumonia, both catarrhal and croupous. In the stage of excavation, whether tubercular or pneumonic, the combination of iodine with carbolic acid and creasote is most potent. The acid seems to have the greater influence in checking the amount and purulent nature of the sputa; while creasote acts more as a sedative to the cough, apparently by reducing the irritability of the pulmonary tissues. The addition, also, of varying proportions of sulphuric ether and chloroform greatly assists in soothing and allaying irritation. These combinations also act frequently like a charm in the profuse expectoration of purulent bronchitis, as also in bronchial asthma. Dr. Thorowgood, in the Lettsomian Lectures for 1879, describes my antiseptic respirator, and adds his valuable testimony to its efficacy in bronchial affections. I have also noticed that patients, while using

this form of inhalation, frequently experience great relief from the aches and flying muscular pains which often occasion much distress in the advanced stages of phthisis.

In connection with these observations, the following formula may be taken as an adaptable basis for the antiseptic solution for inhaling. *R* Tincturæ iodi etherealis, acidi carbolici,  $\text{āā}$   $\text{z̄ii}$ ; creasoti vel thymoli,  $\text{z̄i}$ ; spiritûs vini rect., ad  $\text{z̄i}$ . M. Where cough is urgent, or breathing embarrassed, chloroform or sulphuric ether may be added at discretion. In the formula which I published in 1877, a small quantity of glycerine was introduced, with a view to aid solution and fix the materials; but I found it unnecessary, and also that it clogged the respirator, and soiled everything with which it came in contact.

Whether these substances act by destroying the germs to which the formation of pus is attributed by the great teacher of the antiseptic method, or by their abortive effect from a physical cause, such as coagulation, on the cell-proliferation in the seat of morbid action, I do not profess to know; but the effect of this antiseptic inhalation in diminishing expectoration, and with it the cough, in the various forms of phthisis, during the resolution of pneumonia and in the purulent stage of bronchitis, acute or chronic, with dilated bronchi and fœtid expectoration, is certainly most remarkable. The following are the first four of a list of cases of phthisis, selected by my friend, Dr. Grant, resident physician at the Ventnor Hospital, in which antiseptic inhalation was employed throughout as an adjunct to general treatment.

CASE I.—M. B., aged 32, a tailor. Third stage, right side, with moist crepitations all over the back, and second to third stage at the left apex. He was admitted on January 8th. The sputa were nummular and bloody, four ounces in amount. He was discharged on March 18th; sputa, two drachms, no tinge. He was under treatment ten weeks; he gained 10 lbs.; and was discharged with crepitation much diminished in all parts of the chest, and signs of dry vomice at both apices. The other treatment consisted of hypophosphites and cod-liver oil, with iodine paint over the chest.

CASE II.—E. M., aged 20, a shopwoman, of

strumous cachexia; had very moist apices. Expectoration amounted to four ounces, and was muco-purulent. She was under treatment eighteen weeks. The expectoration was entirely stopped, and she was discharged with the moist sounds greatly diminished and the cavities contracting. There was great long-continued pyrexia in this case. The other treatment consisted of quinine and hydrobromic acid, atropia and oxide of zinc, cod-liver oil, and iodine to the chest.

CASE III.—J.B., aged 25, domestic servant, had phthisis in the third stage at both apices. At first there was considerable pyrexia. The expectoration was three ounces, frothy and muco-purulent; in ten weeks it was reduced to half an ounce. He was discharged with the disease arrested; the physical signs in the right apex as before, and the left apex much drier. The other treatment consisted of quinine and hydrobromic acid, and afterwards quinine and phosphoric acid.

CASE IV.—J. G., aged 31, time-keeper, had the disease in the third stage, very moist, at the right apex; in the first stage at the left apex. Expectoration amounted to one ounce, muco-purulent and nummular; hæmoptysis was intercurrent. After ten weeks' treatment, there was no expectoration; and he was discharged with the cavity completely dried and contracting rapidly, and physical signs absent from the other apex. This patient gained 9½ lbs. The other treatment was chiefly quinine and hydrobromic acid, and ergotine hypodermically for hæmoptysis.

These cases have been taken at random, and are by no means those in which we have seen the best results from antiseptic inhalation on the amount of sputa.

To be able, also, by this means to dispense, to a great extent, with cough-mixtures, *et hoc genus omne*, is in itself no small advantage in the treatment of a class of diseases in which it is so necessary to preserve, if possible, the appetite, with the digestive and assimilative processes undisturbed and intact. If there be sputa collected in the lungs, there must be cough; the *rationale* of treatment then is to prevent, if possible, the material from being secreted which demands cough for its expulsion.

To attempt to stifle a cough under such conditions by sedatives is erroneous in theory, and most dangerous in practice, apart from the other mischievous effects of preparations to which I have already referred.

I may say here, that my later and wider experience of this form of antiseptic inhalation in phthisis laryngea, if such a disease exist *per se*, of which I have grave doubts, or, as I would prefer putting it, in phthisis complicated with affection of the larynx, has not been so favourable as my earlier cases led me to expect. It seems to have too drying or astringent an effect; and, in all such cases, a warm moist vehicle is preferable for the antiseptic material, if such be indicated.

I have now, for nearly five years, employed antiseptic inhalation, as a regular part of the treatment, in all lung-affections characterised by purulent expectoration, both in my private practice and in the Royal National Hospital for Consumption. I find that all patients take to it very readily, become very speedily impressed with the amount of relief it affords, and inclined to continue it on their own account, without the encouragement and suggestion which many other details of treatment often require. Any difficulty on the score of odour is easily met in the great variety, of antiseptic materials from which to choose. I have received a great many communications from members of the profession, many of them in large practice among *poitrinaires*, expressing their high opinion of its value. I am sure the results of this auxiliary to general treatment, in appropriate cases, will be found most encouraging.—*British Medical Journal*.

CARBOLIC OINTMENTS.—Charles L. Schuar, of Chicago, points out in the *Druggist's Circular* that the 95 per cent. aqueous solution of carbolic acid should not be used in the preparations of carbolic ointment, especially with cosmoline, ceraline, vaseline, &c., since the acid is merely incorporated in its pure state in larger or smaller drops, and exerts all the unpleasant effects of the pure acid. If the crystals be employed the dilution is of course proportionate to the quantity of the excipient.



# RINGER ON THE INFLUENCE OF ANÆSTHETICS ON THE HEART: AND ON THE ANTAGONISM OF POISONS.

BY WILLIAM MURRELL, M.D.

Dr. Ringer has recently published two papers (*Practitioner*, June and July, 1881) which throw considerable light on the action of anæsthetics on the heart; and incidentally on the vexed question of antagonism. The observations were made with Roy's apparatus, a description of which will be found in Dr. Roy's paper "On the Influences which Modify the Work of the Heart" (*Jour. of Physiol.*, vol. i, p. 452). Considerable difficulties have hitherto been experienced in working this apparatus, arising chiefly from the inconvenience of having to obtain fresh blood for each experiment.

Dr. Ringer finds that the desiccated defibrinated bullock's blood, imported by Park, Davis & Co., of Detroit, Michigan, answers the purpose admirably. It can be readily obtained, as it is frequently used for enemata, in cases of gastric ulcer, etc. For physiological purposes it is dissolved in distilled water, and then diluted with saline, one part of blood-mixture being used to two of salt solution. In each experiment three ounces were used, the same blood being employed in the same series of observations, so that the poison and its antidote were intermixed.

Chloroform acts powerfully on the ventricle of the frog's heart. Like lactic acid, muscarin, and jaborandi, it lessens both the height and duration of the trace until, finally, the heart is arrested in diastole. In one experiment, a minim of chloroform nearly stopped the ventricle; and, when the heart had almost ceased beating, the addition of two ten-minim doses of strong solution of ammonia at once restored its action, until the contractions became almost as powerful as at first. The addition of ten drops of chloroform again stopped the heart. This shows the powerful paralyzing effect of chloroform, and demonstrates most conclusively the mutual antagonism existing between chloroform and ammonia.

It is clear that chloroform does not arrest the ventricle by stimulating the inhibitory ap-

paratus, for the portion of the heart employed contains no inhibitory nerves. Chloroform clearly paralyzes the muscular substance of the heart, for it is well known that the muscular tissue will beat rhythmically without the presence of nervous ganglia. It is evident, therefore, that, did the chloroform paralyze only the ganglia of the ventricle, the ventricle itself would still continue to beat. Further experiments made with the lower half only of the ventricle render this certain, the ganglionless and nerveless portion being affected in exactly the same way as the whole ventricle.

Atropia does not antagonise the action of chloroform on the ventricle; nor will the previous addition of atropia prevent the action of the chloroform. Ethidene dichloride affects the ventricle in exactly the same way as chloroform. Ether affects the heart in a far less degree than either chloroform or ethidene dichloride. Large doses accelerate the heart's action, and make each beat a little weaker; but the amount of work done is considerably greater, the increased frequency more than compensating for the diminished force of each contraction. Ammonia and ether, like chloroform and ammonia, are mutually antagonistic as regards the whole ventricle. Bromide of ethyl arrests the ventricle, acting on the muscular substance. It is far less powerful than chloroform, but more poisonous than ether.

Iodoform and ammonia are mutually antagonistic, as shown by their action on the ventricle. A fifth of a grain of iodoform nearly stopped the heart, and then ten minims of a one per cent. solution of strong ammonia restored the contractions, which were again arrested by another dose of iodoform. This was repeated on the same heart three successive times.

The importance of these observations cannot be over-estimated, throwing, as they do, a new light on the whole subject of antagonism. Rossbach (*Pflüger's Archiv*. Band xxi, Heft 1, p. 1, 1879) contends that drugs are never mutually antagonistic. He maintains that, when a tissue is paralyzed by one poison, it is impossible to stimulate it by another. For instance, whilst atropia, he says, antagonises pilocarpine, pilocarpine cannot antagonise

atropia; atropia paralyses the sweat-apparatus, and pilocarpine is no longer able to stimulate it into action. He admits that after small doses of atropia pilocarpine can produce sweating, and this he explains by assuming that atropia paralyses first the nerve of the sweat-gland, and later the gland-apparatus itself. After a small dose of atropia the nerve only is paralysed, and then the pilocarpine can still stimulate the glandular cells; but a large dose of atropia paralyses the cells also, and then pilocarpine is powerless.

Dr. Ringer's recent experiments demonstrate the fallacy of this argument. The lower half of the ventricle consists of only one substance, muscular tissue, so that the antagonism cannot be due to an action on different structures.—*London Medical Record*.

#### KLEIN ON THE ETIOLOGY OF MILIARY TUBERCULOSIS.

Dr. E. Klein (*Practitioner*, Aug. 1881), discusses, with his customary thoroughness and ability, in his recent paper, the evidence, still, however, somewhat incomplete, afforded by modern pathology, which favours the view that miliary tuberculosis (using the term in the sense as defined by Virchow, and altogether distinct from caseous inflammation and scrofula) is a specific infectious disease. This evidence may be conveniently stated under three heads.

1. Evidence shows that miliary tuberculosis is communicable from one human being to another. (a). The disease may be inherited, though this is not a distinguishing character of infectious diseases, being associated with certain morbid states distinct from infectious disease, such as cancer or gout, yet, when combined with other features connected with specific disease, it has a certain value, even if an indirect one, more particularly when inheritance is considered in relation to a notoriously infectious disease, syphilis. If the specific infectious character of miliary tuberculosis be admitted, then the so-called special delicacy and vulnerability of the tissues (the only kind of inheritance admitted by some) is simply an accidental and secondary condition, the specific

*materies morbi*, or virus of tuberculosis, being the primary or essential thing. Nothing definite is known as to the period of incubation of tuberculosis. (b). The disease, again, may be acquired in various ways. It may be communicated from husband to wife, or *vice versa*: many instances of this kind are on record. Or it may be communicated from patient to attendant, or *vice versa* (see vol. xi of *Glasgow Med. Jour.*, p. 168). Cohnheim holds that the virus enters the organism most commonly through the air-passages, producing pulmonary or laryngeal tuberculosis; thence it spreads to the bronchial glands and the system at large; or it may enter by the alimentary canal, being swallowed either in food, or in tuberculous sputa, spreading to the mesenteric glands, peritoneum, etc.; or it may attack the urogenital apparatus, or may pass from the upper nasal cavity through the cribrous lamina of the ethmoid bone to the pia mater.

2. We have evidence that tuberculosis is communicable from man to animals, and from animal to animal, in many well-known series of inoculation experiments. In the case of the rabbit and guinea-pig, however, disseminated tuberculosis occurs after inoculation with non-tubercular as well as with tubercular matter, provided they set up inflammation with caseous products; in other animals, in which inoculation did not produce inflammation with caseous products, no disseminated tuberculosis ensued. In Cohnheim and Salomonsen's experiments, a perfectly fresh piece of tuberculous tissue from the human subject was introduced into the anterior chamber of the eye of a rabbit or guinea-pig; in a short time the first irritation passed off, the bit of tissue diminished gradually in size, and then disappeared; after an incubation-period of three weeks, minute gray tubercles appeared suddenly on the iris, which increased in size and underwent caseation. This result followed only and exclusively after the introduction of real tubercular matter. This experiment also furnishes a test, by means of which real tubercular matter may be distinguished from all other caseous, secondary, and chronic inflammatory products, especially scrofula; the tuberculosis of iris in rabbits and guinea-pigs is produced by human tubercle, and



by nothing else. The inhalation experiments of Tappeiner and of Bertheau gave analogous results; nothing but tuberculous materials produced tuberculosis. There are also on record many observations of the transmission of tuberculosis by feeding.

3. There is to be considered evidence as to the nature of the *materies morbi*. The view that miliary tuberculosis depended on the absorption of matter from a caseous focus was supported mainly by inoculation experiments on rabbits, in which tubercular and non-tubercular matter were equally effective. But it was afterwards proved that, for the production of miliary tubercle of the iris with subsequent general tuberculosis in rabbits, real tubercles (grey or caseous) must be employed. It follows, then, that the *materies morbi* is present in the grey tubercle, and is not present in all and every caseous matter, but only in that derived from real tubercles; as regards bovine tuberculosis, it has been shown that the virus is present also in the blood, milk, flesh, and other tissues, but whether this is the case with regard to human tuberculosis has not yet been proved. It has finally been asserted that human tubercular pus contains minute micrococci; that no result follows inoculation with the clear serum of tubercular pus which had been previously freed from solids; that inoculation of the sediment produces the usual result; and that the aqueous humour of an eye affected with tubercle of the iris is effective as an inoculating fluid, only after these tubercles have begun to undergo caseous degeneration.—*London Medical Record*.

#### STOMACH TUBE IN PHTHISIS.

At the session of Oct. 28, of the Hospital Medical Society of Paris, M. Debove reported a case of phthisis that could not retain even milk. It was decided to use the œsophageal catheter. A litre of milk was administered at first; afterwards meat and eggs. Finally, without causing vomiting two litres of milk, meat, and ten eggs were given. The appetite returned, there was an increase of 100 grammes a day in weight; the patient slept well, and the sweats disappeared. M. Dujardin-Beaumez, confirmed these results, and M. Joffroy reported equally favourable results in two cases of cancer of the stomach.—*La France Méd.*

#### SYMPTOMATIC VALUE OF DILATATION OF THE PUPIL IN AFFECTIONS OF THE NERVOUS SYSTEM.

*From La France Médicale.*

The diameter of the pupil depends on various factors: the intensity of the light, the convergence of the visual axes during accommodation and excitation of the great sympathetic. Ræhlmann, after some physiological preludes, considers the movements of the pupil in their relations with the diseases of the nervous system, and formulates as conclusions the following propositions:

I. *Reaction to light*.—(1) If one pupil does not react under the influence of light, whilst the other, left in the shade, contracts, it is not the optic nerve that is injured; there is rather a unilateral paralysis of the pupillary filaments of the corresponding oculo-motor nerve, or else there is some affection of the iris itself.

(2) If the pupil reacts in spite of complete blindness, the cause of this phenomenon should be looked for in the tubercula quadrigemina, which, according to Meynert and Drurin, are in direct connection with the nucleus of the oculo-motor nerve.

II. *Reaction during convergence*.—(3) If both pupils react by the fact of the convergence of the optic axes, the pupillary functions of both oculo-motor nerves are intact; the pupils contract. In order to make this experiment the subject should look at the end of his nose.

(4) If both pupils do not react, either directly or by sympathy, under the influences of light, but react during movements of convergence, and if on the other hand the acuteness of vision, of one or both eyes is satisfactory there is an obstacle in the course of the fibres running from the tubercula quadrigemina to the oculo-motor fibres.

III. *Reaction by excitation of the great sympathetic*.—After having shown in some words the physiological modifications which are felt in the iris after excitation of the great sympathetic, the author arrives at this conclusion, that the pupillary dilatation depends especially on the degree of irritation transmitted from the ganglia and cervical cords to the great sympathetic by the special senses and psychical excitations.

In pathological conditions one notices :—

(5) In debilitated, nervous, and maniacal persons, the normal pupil is very greatly dilated, to such a degree, that the contraction of the pupils always causes a suspicion of commencing general paralysis. In these conditions, as also in the hysterical and epileptic, one often notices an alteration in the oscillations of the pupil, independently of illumination or convergence of the visual axes.

(6) Narrowing of the pupils is symptomatic of disorders connected with diminution of activity of the cerebral cortex, especially in paralytic dementia.

(7) Myosis is met with particularly in affections of the spinal cord. In tabes often the contracted pupils are completely insensible to light, whilst they continue to react by convergence of the axes.

(8) The alterations of the pupils depend on the innervation of the great sympathetic : an excitation of this nerve either at its periphery or at the cervical ganglia, shows itself by pupillary dilatation (Basedow's disease, lead colic, infantile enteritis.)

(9) Dilatation of the pupil is a symptom very characteristic of the respiratory trouble that follows the action of carbonic acid on the spinal marrow, such as whooping cough, vomiting spells, attacks of eclampsia and epilepsy, physical fatigue, and phthisis. This symptom is important in chloroform anæsthesia. Very marked contraction shows that an extreme degree of narcosis has been reached, whilst dilatation under the influence of any excitation, shows that this narcosis is diminishing, but if the pupil dilates suddenly while the narcosis persists, asphyxia is to be feared.

(10) The pupils are dilated when compression of the brain exists, as in cerebral tumours, chronic hydrocephalus, hæmorrhages within the cranial cavity or simple cerebral congestions.

(11) Inequality of the pupils, the mobility being normal, shows irregularity in the innervation of the great sympathetic, irregularity caused by irritation of the nerve acting either at its periphery or at the cerebral or spinal centres. By instilling a little atropine into the eye, one can see whether the dilatation is due to paralysis or irritation. In the first

instance the dilatation will remain slight. In the second it will be more pronounced. Unilateral mydriasis, when the pupil is mobile, is a very important symptom at the commencement of cerebral disease, whilst this same mydriasis where the pupil is immovable (paralysis of the oculo-motor nerve) does not signify much. Dilatation of one side alone, when the pupil reacts normally, is always indicative of unilateral excitation of the sympathetic, and this symptom is very alarming when it occurs, sometimes in one eye, sometimes in the other. Pupils that have been dilated by excitation of the sympathetic, react badly to light, but they contract during movements of convergence; it is thus that this mydriasis, which otherwise leaves the accommodations completely intact, is distinguished from mydriasis from paralysis of the common oculo-motor nerve. Inequality of the pupils is very common among the insane, especially among the paralyzed and demented.

#### VASCULAR TENSION IN KIDNEY AND HEART AFFECTIONS.

In his remarks on "Deviations from the Normal Arterial Tension, Associated with certain Diseases of the Kidneys and Heart, and their Treatment," Dr. McCall Anderson says that "the chief value of the sphygmograph at the bedside is to enable us to gauge the degree of tension, and to register from time to time its variations more correctly than can be done with the finger. High tension is to be relieved by removing the cause. Thus, in acute Bright's disease it is principally due to the diminished urine; and, accordingly, if we succeed in inducing profuse urination, the high tension, as well as the other symptoms, disappears. In chronic Bright's disease, on the other hand, there is often excessive urination, and yet the tension is high, the cause being the stop-cock action of the arterioles throughout the system on the one hand, and the over-action of the frequently hypertrophied left ventricle on the other. In such cases, though we may not be able to remove the chronic disease, yet we can often diminish the tension, and thus may avert certain complications—



cerebral hæmorrhage, for example. This is to be done: 1. By stimulating the organs of excretion. 2. By the administration of medicines which directly lower the tension. The latter are of use, not only with a view of controlling kidney, but also heart complications, such as angina pectoris. 1. Nitrite of amyl lowers the tension and controls angina pectoris. 2. Nitro-glycerine acts more slowly than amyl, but its action is probably more permanently beneficial. A one-per-cent. solution in spirit is used in from one, cautiously increasing up to fifteen, drop doses every three hours. When the tension is unduly low, this may sometimes be rectified: 1. By support and stimulation. 2. By the administration of medicines which directly raise the tension. These are digitalis and casca, the latter in the form of tincture, of the strength of 1 to 10, in five- to ten-minim doses three times a day."—*New York Medical Journal*.

ETHER-OPIMUM TREATMENT OF SMALLPOX.—M. Ducastel, at Hôpital Saint Antoine, has been experimenting with the ether-opiate medication in smallpox. He finds that it prevents suppuration and arrests the eruption. The patients beginning to convalesce from the sixth to the ninth day after the beginning of the eruption. Where suppuration has begun, it is diminished in quantity, and the most painful phenomena are attenuated. The treatment should be begun as soon as possible. His treatment consists in (1) morning and evening, a hypodermic syringe full of ether. (2) Ext. of opium one-fifth to one-half grain in two ounces of water. (3) Perchloride of iron, twenty drops in two ounces of water—the opium and iron are given alternately every hour—a tablespoonful at a time. The treatment should be reserved for the grave forms, as the ether injections give rise to eschars unless they are made deeply into the cellular tissue. This treatment combats the suppuration, and its action is incomparably more marked in those who have been vaccinated.

Warren's experiments on rabbits go to show that Tetanus diminishes the quantity of lactic acid in muscle by one half.

TINCTURE OF CHLORIDE OF IRON.—Dr. Squibb (Druggist, October, 1881) says concerning this that: "In regard to tincture of chloride of iron, the last committee of revision of the pharmacopœia made a mistake which is to be corrected in this revision. Tincture of chloride of iron is not fit for use until at least six months old. I never sent out any that was less than six months old, and now make it a year old. An important part of its therapeutic value depends upon ethers that are generated slowly from the large excess of hydrochloric acid and the alcohol, and any one who compares the sensible properties of an old with a recently made tincture, will see how very different they are. The present pharmacopœia in permitting the acid solution of the chloride to be kept and sold separately, so that the pharmacist can make up his tincture as he wants it, made a great mistake." There is but little doubt that this observation is thoroughly well founded as physicians have long been aware, from clinical experience with this preparation of iron.—*Chicago Medical Review*.

ACUTE MILIARY TUBERCULOSIS MISTAKEN FOR TYPHOID FEVER.—Senator reports a case (*Berlin. Klin. Wochenschrift*,) of acute miliary tuberculosis in a man aged 48, who was for three weeks in hospital under his care, in whom the disease was not suspected. The most prominent symptoms were enlargement of the spleen, fever, roseola, and suppurative parotitis, and at the beginning epistaxis and hiccough. Upon these symptoms, and absence of those pointing to the lungs, the diagnosis of typhoid fever was made. Post mortem: there were no appearances of typhoid, but general tuberculosis of both lungs, spleen, liver, and kidney, and enlargement of the bronchial glands.—*Med. Times—Ohio Med. Journal*.

TREATMENT OF THE VERTIGO OF BRIGHT'S DISEASE.—Dr. Robert Saundby, of Birmingham, speaks highly (*Brit. Med. Jour.*) of the value of caffeine or theine in one, two, or three-grain doses, three times a day, in this distressing, although not very common, symptom in Bright's disease.

**READY METHOD OF PREPARING FOMENTATIONS.**—Take your flannel, folded to the required thickness and size, dampened quite perceptibly with water, but not enough to drip, and place it between the folds of a large newspaper having the edges of the paper lap well over the cloth, so as to give no vent to the steam. Thus prepared, lay it on the heated surface of the stove or register, and in a moment steam is generated from the under surface and has permeated the whole cloth sufficiently to heat it to the required temperature. This method is often very convenient and efficient where there is no opportunity to heat much water at a time.—*Michigan Medical News.*

**PHYSIOLOGY OF THE SPINAL CORD.**—Field experimented in regard to the physiology of the spinal cord by dividing the cord in kittens (nine experiments.) He concludes that co-ordination impulses are conducted by the posterior and lateral columns, voluntary motor impulses by both anterior and lateral columns, and painful sensations and vaso-motor impulses by the lateral columns alone. The lateral columns also contain the inhibitory and sudorific nerves, the latter being placed anteriorly to the former, and both being found in the inner half of the middle third of the column. The gray matter takes no part in the transmission of any of these impulses or sensations.—*N. Y. Medical Journal.*

**HOP BITTERS.**—The following is given as the composition of hop bitters :—

R Tincture of hops.....	3 ss.
Tincture of buchu.....	3 iij.
Tincture of Senega.....	3 iij.
Podophyllin dissolved in spirits of wine.....	3 ss.
Tincture of Cochineal.....	gtt. xx.
Distilled Water.....	to Oj.

M.

These ingredients will cost about ten cents. Selling price, one dollar.

Gruber has observed cases in which accessory portions of liver substance were found in the neighbourhood of the liver, but having no connection with the organ. In the instance which he here adduces two such accessory organs were discovered.—*N. Y. Medical Journal.*

## Surgery.

### OPERATIONS IN VISCERAL DISEASE.

The subject discussed by Mr. Bryant at the Medical Society of London, recently, is of such interest that no apology is needed for noticing it here. The case which formed, as it were, the text for the discussion was that of a young man who for some three years had suffered from disease of the knee-joint, and when he came under Mr. Bryant's care there was evidence of consolidation of both apices of the lungs. The thigh was amputated, the wound healed well, and the chest symptoms improved, while the physical evidence of lung disease diminished. In short, it was a case illustrating, first, the possibility of rapid recovery from a serious operation during the course of phthisis, and, second, the fact that the removal of a chronically diseased joint may be followed by improvement in lung trouble. The case is now by no means isolated, but is one of a series, many of which we have published in our columns from time to time. \* \* \* The cases in which this line of practice may be carried out with most hope of success are, then, those in which the pulmonary trouble is distinctly secondary in point of time to the disease of the bone, and where the bone disease is advanced and attended with pain and discharge, while the lung disease is limited in area and early in stage. In proportion as these conditions become altered the indication for treatment gradually shifts, until where the lung condition is primary, very advanced and wide in its area, or is merely a part of a general tuberculosis, and the bone disease is secondary and early and not attended with suppuration, amputation would only be a means of hastening death.—*London Lancet.*

**TREATMENT OF HYDROCELE.**—Dr. T. L. Ogier, of Charleston, recommends (*Gaillard's Medical Journal*) the injection of 30 drops of strong compound tincture of iodine into the distended vaginal sac without previous evacuation of its contents, as a simple method of curing hydrocele without confinement of the patient. It may be necessary to repeat the injection three or four times at a couple of days' interval.



## PYROGALLIC ACID IN CHANCROID.

MM. Lermoyez and Hitier, one "interne" and the other "externe" of the Paris hospitals, write of the good effects of "Pyrogallie acid in Soft Chancre. It was employed in the form of a vaseline ointment, of the strength of 1: 5. Starch is added to the mixture to stiffen it, and prevent its liquefying after it is applied to the body. The formula is as follows: R Starch, 40 parts; vaseline, 120 parts; pyrogallie acid, 40 parts. Care should be taken to have the ointment fresh. On exposure to the air, it soon became brown and lost its strength. It was found equally applicable to all forms of chancroid, and in all situations. It was only slightly painful, though it had a mild caustic effect when first applied. This caustic action soon disappeared. The pain produced, it is claimed, was not greater than would be caused by the contact of any indifferent body with so sensitive a sore. Under its influence the chancres even when phagedenic, healed with surprising rapidity. — *New York Medical Journal*.

## COMMUNICATION OF SYPHILIS BY SKIN GRAFTING.

Dr. Debel, of Montbeliard, reports in *La France Medicale* of Nov. 1st, the case of a man aged 49, suffering from large ulcerations, following gangrenous erysipelas, for which forty-three grafts had been used. The patient had never had any venereal symptoms. Extension of ulceration, roseola, and mucous patches followed and were cured by specific treatment. Shortly before the roseola appeared the man's son, from whom some of the grafts had been taken, applied for treatment of anal ulcerations, which proved to be mucous patches.

**DRAINAGE OF THE PERICARDIUM.**—A case probably unique in the annals of paracentesis, has been recorded by Rosenstein of Leyden. A child, aged ten years, suffering from pericardial effusion, presented such a degree of interference with circulation and respiration, that an aspirator needle was passed into the fourth inter-costal space near the sternum, and 620 cubic centimetres of liquid were withdrawn.

Left-sided pleural effusion soon followed, and 1,100 cubic centimetres of liquid were evacuated. The cardiac symptoms increased, and necessitated a second puncture of the pericardium; 120 cubic centimetres of purulent liquid were withdrawn. A relapse occurring, a larger opening was made (an inch and a half long) in the fourth intercostal space. The soft parts were divided layer by layer under strict antiseptic precautions. When the pericardial cavity was reached a large quantity of pus escaped. Drainage-tubes were inserted. The operation was followed by an immediate return of the circulation and respiration to normal conditions. An incision into the pleura, however, also became necessary. At the end of four months of treatment the patient left the hospital in good condition. There was no pyrexia or œdema of the skin in the præcordial region to indicate the purulent nature of the effusion.—*London Lancet*.

**MASTOID DISEASE.**—Bezold calls attention to a small class of cases of suppurative otitis media with pus formation in the mastoid, where the process has begun in the air-cells of the mastoid and has subsequently spread to the tympanum. With the ordinary symptoms of middle-ear trouble and marked diminution of the purulent discharge from the tympanic cavity comes a marked increase of all the symptoms pointing to the mastoid process. The pus extends beneath the periosteum in every direction, forward upon the lower jaw, downward into the tissues of the neck, and backward upon the occiput. The point of perforation of the mastoid by the pus must be looked for upon the inner surface or in the incisura mastoidea, and not in the usual locality. In trephining for pus in these cases, Bezold holds that the trephine and chisel must be applied much lower down upon the mastoid process, and the bone must be perforated through its entire thickness, as far as the incisura mastoidea.—*N. Y. Medical Journal*.

**NITRITE OF AMYL IN CHORDEE.**—The *St. Louis Clinical Record* recommends the Nitrite of Amyl in chordee and painful priapism. Three to five drops by inhalation is the appropriate dose.

**THE DEFORMITY OF COXALGIA.**—The articular inflammation is propagated to the muscles which are immediately in relation with the capsule, that is with the psoas and middle and lesser gluteals. The inflammatory contraction of the psoas gives rise to permanent flexion backwards, that of the middle and lesser gluteals to elongation of the limb with abduction. After a certain time these muscles become atrophied and lose their power; then the inflammation is propagated to the more remote muscles—the adductors and sartorius—thus is produced rotation inwards, shortening by elevation of the pelvis, that is to say the metamorphosis of the attitude in the first period of the coxalgia to that of the second period the slow contraction of the healthy muscles at the same time as the powerlessness of the muscles primitively attacked. An important therapeutic inference from this fact is to galvanize the weakened muscles.—*Gaz. Des. Hôp.*—(Verneuil.)

**TREATMENT OF SKIN AFFECTIONS BY NAPHTHOL.**—Recent experiments have been made in Vienna by Professor Kaposi, according to which naphthol has been brought prominently forward as a cure for skin diseases. It appears that the drug acts in a similar manner to tar, of which it is a product, but has no odour, or almost none, and is quite colourless when used in the form of ointment. For scabies an ointment was used of 10 to 15 per cent. strength, and it is asserted that it not only kills the acarus, but that it simultaneously cures the secondary eczema depending upon the parasite. In psoriasis it has also been found very beneficial, neither staining the skin nor the hair. Professor Kaposi hopes by continued experiments to give to the profession some very valuable results.—*Wien. Med. Wochen.*

Méhu (*Archives Générales de Médecine*, Sept. 1881) asserts from very numerous observations that chlosterin in crystals is never met with in fluids which have not been encysted at least six months.

Dr. B. F. Bache, of "Wood & Bache Dispensatory fame," died on the 2nd. November.

## Midwifery.

### UTERINE SUB-INVOLUTION—ITS PATHOLOGY AND TREATMENT.

BY EDWD. ALCORN, M.D.

Of Houstonville Kentucky.

#### ETIOLOGY.

*Local and General Causes.*—Tedious or instrumental labour; laceration of the cervix or perineum; too early rising after delivery; too much and too violent exercise; too early sexual intercourse before involution has taken place; frequent erotic excitement, without intercourse, soon after delivery; cold injections, which are always followed by increased hyperæmia; constipation, inducing pelvic plethora and sluggish circulation. *General Causes.*—Non performance of lactation; flabby anæmia; obese constitution, such as are met with in amenorrhœa or poorly-nourished women, in whom nerve force seems directed to the nutritive and assimilative functions.

Of all causes, local or general, that lead to this diseased condition, too early rising after parturition is the chief, and unquestionably the most frequent. *Symptoms.*—Pelvic weight and dragging backache; supra-pelvic pain; dysuria in the early stages; menorrhagia; later, perhaps, scanty menstruation; ovarian pain, usually located in the left side; a peculiar burning pain on top of the head; leucorrhœa, often profuse and tinged with blood, with burning pain about the vagina and vulva, together with all the hystero-neuroses, usually observed in the female sex. *Pathological Condition.*—Uterus uniformly enlarged, the cavity often admitting the sound three to four inches; soft, flabby, succulent, low in the pelvis, and then generally retro-displaced. Usually endo-trachelitis; catarrh of the endometrium, of a low, chronic type; uterus hyperæmic; cervix bluish red in colour; uterine muscular fibre, areolar tissue and vessels, also parametric tissue, lax; all fibres longer than in the unimpregnated condition. The cavity of the uterus is always increased in size, the cervical glands are hypertrophied, and fungoid growths are often observed. *Treatment.*—All agents whose tendency is to contract the blood-vessels, muscular fibres



and produce absorption of enlarged areolar tissue are indicated. Hot injections, iodine to the cervix and endometrium, carbolic acid and iodized phenol to uterine cavity, saline baths, general friction, massage, electricity—local and by baths (faradic chiefly)—scarification and leeching to the cervix at weekly intervals. Tonics of iron, quinine, strychnine, ergotine, etc. Always reduce any luxation of the organ if existing, unless contra-indicated by old adhesions, and maintain the normal position by a well-fitting, comfortable pessary. All superincumbent weight from the abdomen should be taken away; the clothing should be supported by the shoulders, and not by the hips, as is usually done. In women, whose abdominal muscles are much developed, relaxed and covered with a thick deposit of adipose matter, the external supporters answer a “long felt want.” A lacerated cervix or perineum should always be attended to ere any further steps be taken toward treating a sub-involuted uterus. Injections of hot water, after the method taught by Emmet, of New York, should be used continuously. According to his teaching, all pelvic congestion is venous, and the term “chronic inflammation” is a misnomer, so far as it applies to the organs in that cavity, because the arterial vessels are not involved in that process. It is in the chronic venous congestion, constituting the chief factor in subinvolution and hyperplasia that its use is so beneficial. The douche is preferred to the ordinary syringe; the stream is continuous and uninterrupted; the patient should be prone, hips elevated, thereby emptying the pelvic veins by gravitation. The water should be as hot as can be tolerated. Nervousness and sleeplessness, frequent accompaniments of this morbid condition, are often allayed by the hot douche just before bedtime. Topical applications of Churchill’s tincture of iodine to the uterine cavity by means of a probang are very beneficial. A method preferable is the introduction of soluble medicated bougies into the cavity by means of a hard rubber tube, devised by Dr. Barker, and Mundé, of New York. These tents or bougies are introduced without difficulty and allowed to remain and dissolve, the cervix being plugged with cotton to prevent

the escape of the fluid. Very little pain follows this procedure. Now and then colicky, suprapubic pains supervene in highly nervous subjects, but, as a rule, no pain follows. These bougies are medicated with iodine, iodoform, zinc, etc. The injection of alterative agents into the substance of the cervix has been employed by Mundé, of New York, Bennett, of London, and Delore, of Paris. The first named claims to have had no pleasing results from the method. The experience of Dr. Lusk, of Bellevue Hospital, has by no means been gratifying. He had one case of peritonitis, and death to follow the treatment. Ergotine, iodine, iodide of potassium and chloride of zinc have been the agents employed by these experimenters. Local depletion has proved favourable in the hands of many gynecologists. Dr. Mundé says that the indications for local depletion are two-fold, viz: 1st, to disgorge the loaded uterine vessels in acute inflammation or chronic hyperæmia; and, 2nd, to stimulate the sluggish circulation, either by unloading the estalic veins and the resultant reflux of a fresh stream, or by the nervous shock of the depletion. All authors claim better results from the scarification than the natural or artificial leech. Buttle’s instrument I use through a cylinder speculum. It is thrust into the cervix to the depth of  $\frac{1}{8}$  or  $\frac{1}{4}$  of an inch, and from one to two ounces of blood withdrawn. Secondary hemorrhage rarely follows. A tampon soaked in glycerole of tannin applied to the cervix will preclude the possibility of hemorrhage. The time I prefer for local depletion is immediately after menstruation. The tampon of cotton wool of itself is a valuable agent in the treatment of subinvolution. Its object is to retain the uterus in its normal position or in any position it may be desired to place it, and as a means of sustaining a prolapsed ovary. In addition to this as a mechanical support and stimulus to the pelvic vessels, and an alterative to the pelvic tissue by means of direct pressure. These tampons should be saturated with the glycerole of tannin. The hydragogue effect is sometimes marvellous when allowed to remain twenty-four hours. Sims says of it: “Glycerine has a great affinity for water, and when applied to the cervix, as above directed, it sets up a capillary drainage by os-

mosis, producing a copious watery discharge, depleting the tissues with which it lies in contact and giving them a dry, clean, inoffensive healthy appearance."

The tampon can only be applied satisfactorily by means of a Sims speculum.

Ferruginous tonics should be used continuously in cases where there is a tendency to menorrhagia.

In such cases strychnia, digitalis and all vegetable tonics should be used continuously and persistently during the treatment.—*Walsh's Retrospect.*

#### CASE OF COMPLETE DISAPPEARANCE OF A LARGE UTERINE MYOMA WITHIN SIX MONTHS OF THE REMOVAL OF THE UTERINE APPENDAGES.

*To the Editor of the Lancet.*

SIR,—Dr. Sutton, of Darlaston brought a lady to me in March last suffering from hæmorrhage and retention of urine, due to a large uterine myoma which was shaped like a cocked hat, the upper apex running up as far as the right kidney and the lower resting in the pelvis. To this peculiarity was due the symptom which gave her most distress, the persistent retention of urine. She was thirty-eight years of age and unmarried, and the importance of the case was increased by the fact that she was a relative of her medical attendant.

The tumour had grown very rapidly, for the symptoms had been in existence only a few months. It was quite fixed in the pelvis, so that nothing could be done by lifting it up by means of a ring, and there was no hope of removing it successfully. I therefore proposed to remove the uterine appendages, and this I did with Dr. Sutton's consent and in his presence on the 20th of April last. I was assisted by Mr. Raffles Harmar.

The appendages were extremely difficult to find, as they were all down behind the tumour, and for some time I feared that I should not be able to reach those of the right side. I succeeded however, in getting them completely out, removing the Fallopian tubes close to the uterine cornua. The tumour I estimated to be about five pounds in weight. She

speedily recovered from the operation. She has just been to see me to-day, and tells me that she has never seen the slightest sign of menstruation since the flow which always follows the operation. The use of the catheter was discontinued within a month of the operation, and to day there is not a vestige of the tumour to be discovered; it has entirely disappeared. I am, Sir, yours obediently,

LAWSON TAIT, F.R.C.S.

Birmingham, Oct. 6th, 1881.

#### CAPSICUM IN UTERINE HÆMORRHAGES.

BY J. CHENON.

(From *Le Progres Medical*)

The use of the powder and aqueous extract of *capsicum annuum* (Cayenne pepper) for the past twenty-five years employed with success by Dr. Allégre in the treatment of hæmorrhoids, induced me to study the action of this remedy and extend its application. From a large number of physiological experiments I concluded that capsicum is a vascular remedy, acting especially on organs whose circulation is singularly active, such as the utero-ovarian, respiratory and encephalic. Cayenne pepper acts like ergot of rye on the smooth fibre of the vascular coats, either directly or through the vaso-motors. But it presents a great advantage over ergot, in that it is well borne by the stomach, whose functions it simply stimulates. I have used it for several years in uterine hæmorrhages with the best success, whether these hæmorrhages were due to fibroid tumours, fungous endometritis, or even to epithelioma. The formulæ at which I have arrived are as follows:

R Powdered capsicum, 5 grammes.

Make thirty pills. One before each meal, increasing to six pills a day.

R Aqueous extract of capsicum, 5 grammes.

Make thirty pills. To be given in the same dose as No. 1.

R Tincture of capsicum, 5 grammes,

Rum, 30 "

Gum Julep, 120 "

Take by spoonfuls every two hours.

I have also successfully used capsicum in congestive headaches so common in the gouty, and in the hæmoptysis of tuberculous patients.



## ELYTRORRHAPHY.

Dr. Wallace gives his experience with various operations for prolapsus uteri, consisting chiefly of a narrowing of the lower part of the vagina by means of longitudinal anterior (or anterior and posterior) elytrorrhaphy, more or less modified, according to the nature of the case, and associated with the operation for lacerated cervix, with fixation of the cervix to the anterior wall of the vagina, and with restoration of the perinæum. (His results have been very encouraging, although some of the cases reported offered little promise of success. Of the various procedures described, the one that seems most of a novelty is that of fixing the cervix to the anterior vaginal wall. Taking advantage of a large erosion of the anterior surface of the vaginal portion of the cervix, the latter was stitched to a raw area produced by dissecting up a flap of mucous membrane from the anterior wall of the vagina. It seems to us that this must give rise to a marked and permanent retroversion, and, in the absence of cystocele and with a sound perinæum, thus guard against procidentia by the mere fact that the uterus is unable to present at the vaginal outlet by its short diameter. Such a retroversion of the uterus is not likely of itself to give trouble in a patient past the menopause, and, as the author remarks of versions in general, may not even in younger subjects.)—*N. Y. Medical Journal*.

EXCISION OF A GRAVID CANCEROUS UTERUS. — The total excision of a gravid cancerous uterus was accomplished for the first time in this country by Mr. Spencer Wells, on Friday Oct. 21st. At our last report, four days after operation, the patient was going on wonderfully well. This operation is a combination of Freund's excision of the entire cancerous uterus, and Porro's addition to the Cæsarean section of supra-vaginal amputation of the uterus. The patient was thirty-seven years of age, mother of five children, in the sixth month of pregnancy, and suffering from epithelioma of the cervix. The specimen is now at the College of Surgeons, and will form an important addition to the museum.—*London Lancet*. [Accounts up to Nov. 5th report the case as progressing most satisfactorily.—ED.]

## Correspondence.

To the Editor of the CANADIAN JOURNAL OF MEDICAL SCIENCE.

## SUPRA-PUBIC LITHOTOMY.

SIR,—In your last issue, under the above heading, Dr. Groves, of Fergus, gives "his method of operating, after-treatment and results;" and after stating that the text-books give very meagre information regarding the operation, he makes that his "excuse for presenting a minute account of the manner in which he operated." I presume from the language used in the first sentence that his paper was read before the Ontario Medical Association. Throughout the paper there is no acknowledgment made that he owed even a hint to any source. I have read it carefully over, and can only conclude that the writer wishes it to be understood that the method of operating is original, so far as he is concerned. He says he could get no description in the text-books, etc., but why did he not tell where he did get a full description?

It is a fact that, after repeated examinations, he had decided not to operate at all on his first patient, but to keep him as comfortable as he could by medication. And it was not till after the supra-pubic method had been suggested to him, and his attention directed to an able article by Dr. Dulles, in the July number of the *American Journal of Medical Science*, 1875, that he decided to attempt surgical relief. Under the circumstances, therefore, it is rather refreshing to hear him describe his method of operating, etc.; and it is somewhat humiliating to the Ontario Medical Association that one of the papers, read at its first meeting, should be an open plagiarism of an article that appeared six years ago in a journal so eminently respectable, and widely circulated as the *American Quarterly*, and that it should pass unchallenged. It was in the article above-mentioned that he got the description he could not get in the text-books, and from it he gleaned all he knows of the supra-pubic method.

I may add that I have serious apprehension that the writer of the paper is much too intimate with the reporters of secular papers. The article he favoured your readers with is but a small affair as compared with the glowing

account given by a local paper, in which we meet with terms—very unfamiliar to other than professional ears—from the use of which its origin may be inferred.

Yours respectfully,  
ANGUS MCKINNON.

Guelph, Nov. 8th, 1881.

[We are of opinion that if Dr. McKinnon will re-read Dr. Groves' article he will come to the conclusion that the latter does not profess to be describing "his" operation for supra-pubic lithotomy, but merely the mode of operating pursued in his case; and that, moreover, if he will take the trouble to compare Dr. Groves' description of the operation with those given by Erichsen, Bryant, Ashurst, Hamilton, Gant, Gross, Bernard and Huette, and even old Cheselden himself, he will find as much evidence of plagiarism from them as from Dulles's article above referred to. That there had been any deliberate or conscious plagiarism with intent to defraud, we should be loth to believe. We are glad, however, to have the subject of supra-pubic lithotomy again referred to, for we believe, with Podrazki and Dulles, that it is the appropriate operation for children at all times, and that through the fatality of fashion it has been too much neglected in consequence of Cheselden's premature abandonment of it. When employed in the adult there is a very good method, advocated by Petersen and certain French surgeons, of causing the bladder to rise up out of the pelvis, in conjunction with its distention with water, viz.:—the inflation of the rectum with Gariel's air pessary or other similar means. We observe that Dr. Groves did not suture the bladder. In the three cases which have fallen under our observation the recommendation of Dulles and the German surgeons has been followed in this respect we think with advantage the incision in the viscus being tightly closed with carbolized catgut. With respect to the last allegation contained in our correspondent's letter we sincerely trust that it may prove to be entirely erroneous and unfounded, since the despicable practice complained of is growing to be much too common in our midst, and is one to which no respectable member of the profession could by any means be induced to lend himself.—ED.]

THE CANADIAN  
**Journal of Medical Science,**

A Monthly Journal of Medical Science, Criticism,  
and News.

TO CORRESPONDENTS.—*We shall be glad to receive from our friends everywhere, current medical news of general interest. Secretaries of County or Territorial medical associations will oblige by forwarding reports of the proceedings of their Associations*

TORONTO, DECEMBER, 1881.

ANNUAL DINNER OF THE TORONTO  
SCHOOL OF MEDICINE.

The Eighth Annual Dinner of the Toronto School of Medicine was held in the Queen's Hotel, on Thursday evening, November 10th, and was without doubt, in all respects the most successful medical dinner that has ever been given in the Province of Ontario. A large number of guests, representing all shades of religion and politics, all teaching institutions from the universities down to the public schools, and all the learned professions, together with the members of the Faculty of the Toronto School, many of its graduates, and most of its undergraduates, sat down, or attempted to sit down, at the tables where one hundred and fifty seats had been provided, but were found to be quite insufficient. The good-natured host soon, however, had a couple of extra tables provided, and, with a little crowding all were accommodated, and apparently perfectly satisfied with the sumptuous repast so tastefully arranged on the long tables.

We were very much pleased to see an unusually large number of former students of the school, and we hope to see the numbers of old graduates increasing from year to year at these annual gatherings. While they must derive much pleasure for themselves, they at the same time give much encouragement to their old preceptors, who always retain a most kindly feeling for them after they leave the school to engage in active practice; and, perhaps, still more encouragement to the enthusiastic and energetic undergraduates, who work so indefatigably to



make these dinners a thorough source of enjoyment to the guests, the members of the faculty, and the graduates who honour them by their presence.

Among the guests were Hon. E. Blake, Chancellor of the University of Toronto, Prof. Reynar, of Victoria University, Prof. Cavan, of Knox College, Rev. Septimus Jones, of the Protestant Episcopal Divinity College, Rev. Drs. Potts and Wild, Dr. McDonald, of Hamilton, Dr. Tye, of Thamesville, Drs. Burns, Strange, Temple, Fulton, Kennedy, O'Reilly, and Clark, of Toronto, Prin. Buchan, of Upper Canada College, Mr. Geo. Dickson, of Hamilton, Profs. Loudon and Pike, Messrs. D. McCarthy, M.P., Jas. Beaty, M.P.,—Badgerow, M.P.P., Falconbridge, etc.; and among the graduates were Drs. Armstrong, Kitchen, Bascom, Eccles, McConnell, J. Robinson, G. B. Smith, Sweetnam, Charlton, Cameron, J. R. Jones, Mennie, Jno. S. King, Watt, Buchan, and others.

Mr. E. G. Knill, a student of the fourth year, occupied the chair, and, in his conduct of the proceedings, displayed so much good judgment, tact, and ability, that the programme was carried out from beginning to end without a jar or accident of any kind. Mr. R. M. Coulter, another fourth year's man, occupied the first vice-chair, and in proposing the toasts allotted to him, delivered concise, appropriate and racy speeches, which were received with much applause. Mr. J. S. Draper, a second year's man, occupied the second vice-chair, and in proposing the toasts to the Freshmen and the Ladies, spoke in a very suitable and happy strain.

Among the responses of the undergraduates, that of the Graduating Class excited the most interest. Mr. W. H. Montague, who responded, is endowed with an unusually fine voice, excellent style of delivery, and good command of the Queen's English; and the very able speech which he delivered was listened to with marked attention, and received with the most enthusiastic applause. He referred in glowing terms to the character of the teaching received by the students; paid a high tribute to the ability and zeal of the members of the faculty; pointed with pride to the records of the school, which showed that since 1870 its students had

obtained about 85 per cent. of the medals given by the Medical Department of the University of Toronto; alluded to the host of "our" graduates scattered throughout the country, and the high positions attained by a large number of them; and closed his eloquent speech by a humorous allusion to those who expected to form the Graduating Class next spring.

Mr. A. T. Rice responded for the Freshmen, and Mr. Patterson for the Ladies, and although these speeches were delivered at rather a late hour, they were well received. Mr. Wallace, the able and popular student who represented the undergraduates of the sister Medical Institution of Toronto, when rising to respond in their behalf, was received in the most friendly and cordial manner.

We regret to be unable to make any reference to the excellent speeches delivered by the Hon. Edward Blake, Prof. Reynar, Dr. Cavan, Rev. S. Jones, Dr. Tye, of Thamesville, Dr. Burns, Drs. Aikins, Barrett, and Richardson, of the Toronto School Faculty, Dr. Kennedy, of the Trinity School Faculty, and several others.

We must simply, in conclusion, congratulate the students, as represented by their Committee, including the active and energetic Secretary, Mr. F. P. Drake, upon the thoroughly complete success which attended the banquet from beginning to end, and in this connection we must refer particularly to the efforts of the Glee Club, which added so much to the pleasure of all present. The interest and enthusiasm were well sustained until 1.30 a.m., when the proceedings closed with "Auld Lang Syne."

#### ELECTION TO THE UNIVERSITY SENATE.

Owing to the lamented death of Archibald Frederick Campbell, M.A., it devolved upon the Senate at its last meeting, on the 25th ult., to elect a successor for the remainder of his unexpired term of office. We understand that the unanimous choice of the meeting fell upon Laughlin McFarlane, M.B., and we congratulate the Senate upon his election, not only because during a former long tenure of the post he discharged the duties most zealously, efficiently, and faithfully, but, also, because at the last election the ballots of the graduates indicated him as their next choice.

## ANNUAL DINNER OF THE TRINITY MEDICAL SCHOOL.

The Annual Dinner of this prosperous school was held in the Rossin House, on Thursday evening, November 3rd. A large number of guests, and nearly all the members of the Faculty sat down with the students, and a very enjoyable evening was spent. There were altogether 126 present. Mr. Natrass acted as chairman, and in his opening address alluded to the prosperity of the school as shown especially by the large number in the Freshman Class this year. He also eulogized the Faculty, and praised their ability and plan of teaching, but suggested that still more clinical and catechistic teaching might be advisable.

The Attorney-General referred to the excellent condition of the Toronto General Hospital under the present management, and also to the high standard of medical education in Ontario, and, after alluding to the great progress made in the Medical Art during the present century, paid a high tribute to the medical profession throughout the world. His Worship the Mayor mentioned the important fact that there was no doctor in the City Council, and thought that one was wanted, especially recently, to probe the wounds and mutilations which had been made in one of the city contracts.

The first Vice-Chairman, in proposing the toast of the Universities and sister Institutions, spoke of the good feeling which existed between the two medical schools of Toronto, and expressed the great pleasure he felt in extending a very cordial welcome to Mr. Cleland, the Representative from the Students of Toronto School of Medicine, who was present.

Mr. Mulock, Vice-Chancellor of Toronto University, in replying for that Institution, referred to the high theoretical attainments of Canadian medical students, but regretted their deficiency in practical training; and alluded to the advisability of amalgamating the two schools of medicine in Toronto, but declined to offer any opinion on the question.

Dr. Graham, who responded for the Faculty of the Toronto School of Medicine, preferred two schools in Toronto, as the number of

students was so large that there was more work than one school could well attend to. He expressed the hope that more attention would be paid to practical examinations, and signified his pleasure at the steps which had already been taken in this direction by Toronto University and the Ontario Medical Council, but hoped that they would do still more. He would like to see certificates of having acted as clinical clerks and surgical dressers required from the students.

Mr. Cleland, on behalf of the undergraduates of the same school, made an appropriate response which was well received.

Dr. Allison on behalf of the Ontario Medical Council thought a two years' term was long enough for examiners, and regretted the appointment of "one examiner" at last meeting of Council.

Dr. Burns wished to impress on the students the fact that the members of the Council entertained the most kindly feelings towards them, but at the same time wished to make the examinations just and fair in every respect.

Dr. Geikie, who, in responding for the Faculty, was enthusiastically received by the students, thanked them for the cordial feeling shown by them towards the teachers in the school. He referred to the prosperity of the school, as shown by the fact that the members had increased in a few years from 57 to 160 in actual attendance. He quite agreed with the sentiments expressed by Dr. Allison with reference to the appointments of examiners, and thought that "one" he alluded to should not have been appointed. He also referred with grief and pain to the extraordinary spectacle enacted, when the President of the Ontario Medical Council, at its last meeting, left the Chair, and exhausted himself in abusing and insulting the students; yes, he would repeat it, though he confessed it took a great deal to exhaust the gentleman in question, yet he did exhaust himself on that occasion, and he hoped he would never see the like again, because he thought that act had done the Council more harm than could be undone by five years of wise legislation.

Several other toasts followed which were well proposed and accompanied by appropriate responses. We regret that want of space prevents us from giving any report of them.



## LAY SUPERVISION OF MEDICAL INSTITUTIONS.

We transcribe the following from the *Chicago Medical Review*, not because we regard it as specially applicable to ourselves, but because we look upon the principle enunciated as sound and true, as universally applicable and finally to prevail. Hospitals are institutions for the care and cure of the sick, and all other ends and objects must be made subservient to this, cost what it cost. It would be as reasonable to expect a medical man to manage a bank, or preside in a court of justice, as to entrust to the hands of a lay committee the management of a house for the cure of the sick. Every such Board should, therefore, have a medical majority at its deliberations.

"A matter that certainly threatens the independence of the profession is the lay supervision and control of various medical institutions. Numerous evils have resulted from this during the past decade, and the outlook for the future is by no means promising. The recent scandalous occurrences at Guy's Hospital, London, the arbitrary dismissal of consulting physicians to the Presbyterian Hospital, New York, and certain occurrences of similar tenor in connection with Bellevue and other hospitals in various cities, show that the lay control of institutions devoted to the care of invalids, results in lowering public estimation of the profession, in diminishing the efficacy of hospitals, and in conducting them on a purely economical basis. The same remark holds good of asylums for the insane, which are in many instances but sops to the thirst for internal improvements of certain localities. A board of local trustees is chosen for these, and these gentlemen generally choose a medical man in obedience to the same solicitation for the welfare of local interests. The result of this is that the hospital or asylum, as the case may be, is run purely as a show establishment, its efficiency is judged chiefly by the amount of dollars saved out of the annual appropriation. If the hospital be municipal, there is generally a lay superintendent chosen, whose ability has hitherto been chiefly displayed in the direction of controlling the primaries of his party, and

the office under him becomes simply a means of rewarding fourth and fifth rate politicians. This system of lay supervision has in many states resulted in the prevention of the proper utilization of the clinical advantages offered by the hospitals, and in numerous unsavory scandals. To such an extent has this lay supervision been carried, that the health officer, a purely medical position, is a layman, generally set in his ideas, and ignorant of all sanitary science. This state of things is both a disgrace and a danger to the profession, the more so as it is easily remediable. The different local medical societies could soon regulate this matter if they would but resolve that it is inconsistent with the dignity of the profession, with the best interests of the community, that any public institution charged with the care of invalids or the care of the insane, should be under lay control. A course of social tabooing of such physicians as went against the sense of the profession as thus expressed, would soon place the various hospital and other authorities in such a position that they would be compelled to bow to the views of the profession. Until this is done, clinical opportunities will continue to be wasted, social cliques will continue to regulate hospital appointments."—*Chicago Medical Review*.

## THE ONTARIO MEDICAL COUNCIL AND THE MEDICAL DINNERS.

From the sentiments expressed at the recent medical dinners it is quite evident that the Medical Council does not command the respect which it is desirable it should, either among the laity or the profession (including the teachers as well as students). While we must respect the dignified manner in which Mr. Knill, the chairman of the Toronto School dinner treated the subject, we could not but regret that there was any occasion for his reference to the "unseemly squabbles" which have occurred in the past between the students and the Council.

While listening to the able and interesting speech of the Rev. Dr. Wild, we were impressed with the idea, while he was "knocking the Council on the head," that he did not possess

the same intimate knowledge of the subject that he has shown concerning the "lost tribes of Israel."

We were, however, especially grieved to hear remarks made by two members of the Council to the students at the Trinity School dinner. It was very poor policy, to say the least of it, to endeavour to create any feeling of distrust among the students towards the Examining Board by objecting to the appointment of "one examiner, you know, who." In fact we may go further and say it was simply contemptible to make such an attack upon any man where neither he nor his friends were in a position to resent it. The worthy Dean of Trinity School not only endorsed this objection to "one Examiner," but went so far as to make a violent personal attack upon the President of the Medical Council. We will not at this time discuss the speech of the gentleman referred to on the subject of the student's petition, as we, in a former number of this Journal, took occasion to object strongly to some of his expressions concerning the students; but we must express the opinion that the learned Professor was extremely injudicious, while speaking to his one hundred and sixty students, to make any attempt to create a hostile feeling among those young men towards the Council or any of its members. It would have been more dignified and profitable either to uphold the Council, of which he himself, is one of the most distinguished and influential members, or if he could not do that, to pass this part of the subject over in silence, and endeavour to impress on the students the importance of preparing themselves thoroughly for their examinations, instead of giving direct encouragement to petitioning or abusing this body, if they are so unfortunate as to be rejected next spring. Probably if he had made the same attack on the President at the close of the speech, to which he objects he would not have found the amount of "exhaustion" he now imagines; and we cannot but think that some instinctive idea of this kind was present in his mind; otherwise, we are at a loss to account for his meek and lamb-like aspect at that time, which presented so striking a contrast when compared with his bellicose words and warlike attitude while recently addressing the one hundred and sixty.

## SYSTEMS AND CURES IN MEDICINE.

### THE DANGER AND THE DUTY OF THE HOUR.

There cannot possibly be a "system" or "cure" in medicine. There are no rule-of-thumb methods and no mysteries in true science. If we do not know what a remedy is, and how it acts, we have no right, as honest men, to employ it. The time has passed for the working of cures by charms and the recourse to nostrums. We pander to the credulity of the unskilled community when we show ourselves credulous. We patronize and encourage quackery when we extend professional recognition to a quack. Every man is a quack—whether qualified or unqualified—who employs a remedy without knowing why, or who adopts a "system" in medicine. The profession must speak out clearly and strongly on this point, and without delay. From the highest places in society to the lowest ranks of the people, there is just now a grievous readiness to "believe in" quacks and quackery. We have ourselves to thank for this most adverse "feeling" and "influence." It is the stirring of the viper we have brought in from the cold, where physicians and surgeons of more robust intelligence than those of to-day left it—the viper we have warmed and fed and brought back to life; and now it is preparing to rise and sting the hand that caressed it. The way to encounter the charlatanry which is making head against science is to be at once more candid and more conspicuously honest in our dealings with the public. We must lay aside the last vestige of the robe of mystery, and show by our words and works, our conduct and policy, that medicine is not a science that admits of inspiration, and that the practice of healing is not an art which can be acquired by the unlearned. There is no system or cure, or charm or nostrum, known to the profession; our calling consists solely in the rational study and treatment of diseases on common-sense principles. For those who pretend to a sort of inspiration we have no professional friendship; and towards the promoters of systems and 'pathies we can have no leaning, or any feeling other than that of suspicion, if not pity and contempt. They can have no place in our pro-



fessional intercourse, and we can have nothing to say to them or their work. This is the only sentiment worthy of the medical profession in its dealings with medical quacks, and the time has come when the revival of its old spirit is most earnestly to be desired.—*London Lancet*.

#### WASTED OPPORTUNITIES.

To the thoughtful mind, the waste of clinical opportunity observable in our large medical centres, and in Philadelphia perhaps no less than elsewhere, appears deplorable and discreditable. While the question of misplaced medical charity and of excessive gratuitous treatment has aroused no little attention, yet it must be remembered that the medical profession at large may be losers in more ways than through the pocket. The scores of young professional men who seize eagerly on each vacant position occurring in dispensaries and out-patient departments of hospitals too often forget that in entering upon the privileges of these posts they at the same time tacitly assume the obligation to themselves, as well as to their profession, to make the best possible use of the chances offered for recording unusual cases, experimenting with new remedies, or even the collection of statistics. That this may be done is shown from the fact that some of the most creditable papers appearing in our journals or read before our societies are from the few younger men whose only opportunity for clinical research is found in our out-patient or dispensary practice. In fact, books reflecting honour on the writers and on the profession of this city have within recent years been written by those who have had no beds in hospitals nor even the large clinical advantages enjoyed by the considerable number of young hospital and dispensary doctors whose chief ambition at times appears to be to get through the day's work and have it over with, and who are content to prescribe "house-mixtures" and "Pill 3" or "4" as the quickest way of disposing of cases, while numerous problems to be solved are lying ready to hand and calling for study and investigation.

Bacon, in an oft-quoted aphorism, says that "every man is to be held a debtor to his pro-

fession; from the which as men of course do seek countenance and profit, so ought they of duty to endeavour themselves, by way of amends, to be a help and ornament thereunto." Would that this wholesome sentiment could be graven on the walls of every hospital and clinic!—*Philadelphia Medical Times*.

#### ONTARIO MEDICAL ASSOCIATION AND DIVISION QUARTERLY MEETINGS.

It has been considered advisable by some members of the Ontario Medical Association to have local meetings in each of the four divisions of the Province, convened by the Vice-Presidents, in the months of September, December, and March; and Dr. J. E. White, the General Secretary, has communicated with the different Vice-Presidents and Local Secretaries, asking for their opinions on the subject. Through the kindness of Dr. White, we have had an opportunity of looking over the various replies, and find there is by no means an unanimity of feeling in favour of the scheme. In fact two of the three Vice-Presidents who have replied are opposed to it, and under these circumstances we think it would be very unwise to urge its adoption, at least before the next general meeting to be held in June, 1882. We can see nothing to be gained by the proposed plan, as it would probably interfere with many city, county, and electoral division societies already organized throughout the Province, and in our opinion, the aim of the General Association should rather be to give these its countenance, and court their reciprocal favour and support.

#### A BUREAU OF PUBLIC HEALTH.

In order that the representations which are to be made to Parliament during the ensuing session, as to the desirability, nay, the absolute necessity, of establishing a Public Health department, it is desired to secure as many medical signatures as possible to a petition setting forth such necessity, and with this object in view blanks have been issued, some of which will be found enclosed in our present issue and others in that of the *Canada Lancet*. It is to be hoped that members of the profession in all

parts will not neglect to sign the blanks at once and return them under cover either to us or the *Canada Lancet* without delay. We deem it highly superfluous, to add a single word to medical men in enforcing either the propriety or desirability of such a step, merely reminding them that our strength lies in unity and unanimity of expression, and recalling the time-vindicated maxim, *Concordia res parvae crescunt discordia, maximæ civitates dilabuntur*.

The prosecution of Ferrier for vivisection at the late International Medical Congress has fallen through, it appearing that the animals were not then vivisected, but merely pinched. It will probably be in the recollection of our readers that the animals referred to were two monkeys and a dog, the former the property of Dr. Ferrier, the latter of Prof. Goltz, having been brought over by him to invalidate the theory of central localization, as presenting an instance in which the cortical motor centres of an animal had been removed and yet the animal had retained, or regained, voluntary control over the parts whose supposed governing centres had been destroyed. Ferrier's monkeys were examples of complete and permanent loss of power after cortical destroying lesions, and in order to explain the apparent discrepancy in the facts, it was agreed to test the matter by killing the dog and one monkey and submitting their brains to a committee appointed by the Congress for their examination. It is now well known that the result showed imperfect destruction of the centres in the case of the dog, and complete in the case of the monkey, a creditable vindication of British experimental physiology which the law of the land has done so much to curb, shackle, and repress in the country of its second birth and grandest achievements.

**THERAPEUTICS.** — We purpose, during the coming year, to publish in the *Journal*, bi-monthly, notes on Therapeutics from the able pen of Dr. Richard L. Macdonnell, of McGill College, Montreal.

## PERSONAL.

Dr. E. Graves Kittson, has gone from Hamilton to Winnipeg where he is now practising.

Dr. Jonathan Robinson, who was for some years in the North-West Territory, has settled in Toronto, 448 King Street E.

Dr. G. B. Smith, a graduate of 1880, and recently from Toronto General Hospital, has settled in Queen St. E., Toronto.

Dr. Geo. Wilcock, a recent graduate from the Toronto School of Medicine, has returned from Edinburgh and settled in this city, on Queen Street West.

Dr. Abraham McMichael, who practised in Gorrie, in the County of Huron, since 1869, the year he graduated, died on the 17th November, of typhoid fever, being 44 years of age.

Dr. Rosebrugh, of Hamilton, has been elected to the Ontario Medical Council, as the representative of Victoria College and successor to the late Senator Brouse, M. D.

The recent illness of the venerable Dr. Ryerson, which for a time gave his friends so much anxiety, was caused by pneumonia, involving the whole of the left lung. The Dr. is 78 years of age.

J. Howard Betts, of the Kingston School; Herman E. Heyd, of McGill, and W. A. D. Montgomery, of the Toronto School, passed the primary examination for the M. R. C. S. Eng., on the 7th, 8th, and 9th November, respectively.

Dr. Wm. McKay, who graduated in Toronto University in 1863, and was living in Howick, Province of Quebec for many years, has moved to Toronto. He is living now on Spadina Ave., No. 259.

Drs. William Gunn, of Woodville, Ontario, and Howard Roxboro Elliott, of Iroquois, Ontario, received the double qualification of L. R. C. P. and L. R. C. S., Edinburgh, at the October Examination. Drs. Elliott and Gunn were students of the Toronto School of Medicine.

Dr. Macdonald, of Hamilton, has been elected President of the Hamilton Association for



the ensuing year. The Association is one for the reading and discussion of scientific papers, somewhat similar to our "Canadian Institute," and we cordially congratulate it upon its choice of President.

We regret very much to learn that Dr. Andrew Luke, who has been in successful practice in Manilla, Ont., for the past seven or eight years, is obliged, on account of ill-health, to seek a permanent home in California, whither he starts this week. We sincerely trust that California's genial climate may suffice to restore his vigour, and knowing that its people are appreciative of the sterling qualities, both professional and private, which we know him to possess, we bespeak for him an honourable and prosperous career in the home of his adoption.

CANADIANS ABROAD.—James L. Foley, M.D., and James Ross, M.D., McGill, were admitted L.R.C.P. Lond. on 27th October.

### Obituaries.

#### WILLIAM FLETCHER, B.A.

(*Non Res, sed spes erat.*)

It is with exceeding great regret that we are called upon to chronicle this month the premature demise of this promising and accomplished student of medicine. Mr. Fletcher received his preliminary education at Upper Canada College; entered University College in 1871, and graduated in arts, in the University of Toronto, in 1875, carrying off the scholarship throughout his course, and securing, on graduating, the Gold Medal in Science and the Prince's Prize. He then entered upon the study of the law in the office of Messrs. Blake, Kerr & Boyd, completed the course, but did not present himself for "call to the bar." During the same time he read for the LL.B. degree in the University of Toronto; but at the final examination had the misfortune to lose the last paper, owing to a change in the programme, of which he was unaware. He entered as a student in the Toronto School of Medicine in 1879, and displayed much clinical zeal and

activity in the wards of the Toronto General Hospital. During the summer months he has been, for some years past, engaged in the geological surveys of Cape Breton, of which his brother is in charge; and during the past summer he collected the materials for an account of leprosy in that Province, which was published by his brother-in-law, Dr. McPhedran, in these columns, a couple of months ago. It was his intention to spend this winter in clinical study in New York, preparatory to graduating in medicine in his old *Alma Mater* in the spring; but on the very eve of his departure in attempting to ford a turbulent stream the rush of waters overcame his foothold, he was carried over a neighbouring fall and drowned. Coming of a family whose attainments in scholarship have been marked, he did not fail to contribute his quota to sustain its reputation, and those who knew him best looked forward in fond anticipation to the time when the refinement of scholarship and the power of science should combine to enhance his capabilities for great achievements in the relief of suffering human kind. But *l'homme propose, mais Dieu dispose*, and as we drop the tear of earthly affection and regret upon his early grave we are solaced by the faith that in another, although unknown, sphere there must be other, mayhap, nobler, work to do.

France has at length lost the veteran Bouilaud, who succumbed in the end of October, at the advanced age of 86. He was, perhaps, the most widely-known of Parisian physicians, and was for many years the link between his contemporaries of the past, Petit, Serres, Louis, Chomel, Bretonneau, and Forget, and the immediate present. A genuine *laudator temporis acti*, he was ever wont when any claim to recent discovery was on the *tapis*, with wonderful facility of diction and prodigious memory, to ransack the history of medicine from the time of Galen, to demonstrate the falsity of *aliquid sub sole novi*. An ardent disciple of Broussais, he bled *coup sur coup, ad deliquium animi*. His published writings cover almost the whole range of clinical medicine, but notably concerning the relations between cardiac affec-

tions and rheumatism, and the localization of the seat of aphasia in the frontal convolutions of the left hemisphere. He was an honorary professor in the Faculty of Medicine and a former dean, an ex-member of the Superior Council of Public Instruction, an ex-Deputy and a Commander of the Legion of Honour, likewise a member of the Academy of Medicine and of the Academy of Science.

Dr. David Foulis, Pathologist to the Royal Infirmary, the rising and distinguished Glasgow surgeon, who was the first in Britain to successfully extirpate the larynx, an operation which he twice performed, died at the early age of 35, on the 31st of October, from diphtheria contracted in performing tracheotomy on two virulent cases of that disease. He was the discoverer of the microscopic evidences of malignancy in ovarian fluids.

Dr. Hayden, of Dublin, author of the Encyclopædic Work on Heart Disease, died on Oct. 30th. Dr. McClintock was President, Dr. Hayden, President-elect of the Dublin branch of the British Medical Association.

Dr. Alfred H. McClintock, of Dublin, Former Master of the Rotunda, died on the 21st of October, from a combined cardiac and cerebral affection, at the age of 60 years.

**THE LIVER PAD OUTDONE.**—The *Michigan Medical News* tells of a doctor in Iowa who has invented an anal pad, by which the fæces are changed into gas, and the gas is deodorized, purified, and burned as a chamber light. It acts on the same principle as Holman's Liver Pad, and if worn over the mouth sweetens the breath, prevents cursing and swearing, and destroys the appetite for tobacco.—*Gaillard's Medical Journal*.

Doctors were humorously compared by Addison to the army of Ancient Britons, described by Julius Cæsar: "some slay on foot and some in chariots, but those in chariots do the most execution."

## Book Notices.

*Transactions of the Medical and Chirurgical Faculty of Maryland. Eighty-third Annual Session held at Baltimore, Md., April, 1881.*

*Observations on the Origin, Character, and Treatment of Oinomania.* By T. L. Wright, M.D., Bellefontaine, O. (Reprint from the *Alienist and Neurologist*.)

*Thirty-Ninth Report to the Legislature of Massachusetts of Births, Marriages, and Deaths in the Commonwealth, for the year ending Dec. 31, 1880.*

*Rudolf Virchow.*—An address introductory to the course of Lectures of the term 1881-82. College of Physicians and Surgeons of New York. By A. JACOB, M.D., Clin. Prof. Dis. of Children (Reprint from *Medical Record*.)

*Walsh's Physicians' Combined Call Book and Tablet.* (Sixth edition.) Ralph Walsh, M.D., 332 C. Street, Washington, D.C.

This list differs from most in having the names of the months and days of the week left blank, and may, therefore, be called perpetual. Each page is ruled for 34 names. The usual information found in the front pages of such books is not wanting, but would be better in the head of the practitioner than in his pocket. The book is handsomely issued in red Russia, and is of good size and shape for carrying in the pocket.

*The Medical Record Visiting List for 1882.*

We are in receipt of Wood's Visiting List, 1882, which comes in its usual attractive and substantial form, ruled for 30 or for 60 patients per week. Besides the ordinary weekly ruling, with columns for charges, ledger reference, and special memoranda, it contains blanks ruled for particulars in consultation practice, obstetric practice, obstetric engagements, nurses' addresses, cash account, &c., as well as the customary tables, posological, toxicological, and other, obstetric reckoner and useful memoranda concerning the urine, &c.



*Landmarks' Medical and Surgical.* By LUTHER HOLDEN, with additions by Wm. W. Keen, M.D. H. C. Lea's, Son & Co., Philadelphia. N. Ure & Co., Toronto.

It is a wonder that the surpassing excellences of this work should have so long escaped the searching eyes of the American book-makers. At last, however, it makes its appearance in a neat and pleasant garb. The well-known anatomist, Dr. W. W. Keen, has added a few artistic touches which will, perhaps, render the book more acceptable to the American reader. The merits of the work were so evident that additions, not improvements, were made by the editor. Student and practitioner, physician and surgeon, all should study it carefully until they have thoroughly mastered its contents and have them at their finger tips.

*The Physician's Clinical Record for Hospital or Private Practice,* with Memoranda for Examining Patients, Temperature, Chart, &c. Philadelphia: D. G. Brinton, 115 South Seventh St.

The title sufficiently explains the character of the publication. It is a little blank book, about 6 inches by  $3\frac{1}{2}$ , ruled for notes of a hundred cases or more. Each case occupies a page, with lines for name, address, disease, and columns for date, pulse, respiration, temperature, other symptoms and remarks. A dozen temperature charts are bound in, as well as a lettered index, and a few blank pages for outline sketches, to facilitate which a small stencil plate is contained in the pocket in the cover. We commend it as very handy and likely to promote daily records, now so much neglected to the detriment of all.

*Vennor's Almanac & Weather Record,* for 1882.

By HENRY G. VENNOR F. G. S. Philadelphia: J. M. Stoddart. Toronto: Toronto News Company.

Mr. Vennor regards Toronto as most exceptional, *re* the weather, and he certainly has not been particularly happy in his prognostications for this locality.

— Mr. Vennor claims to have found the key of the problem of weather prediction. His prognostications are not mere guesses, but are

based upon the principle of recurrent waves of like duration at intervals of time. Thus there are singlets, couplets, and triads of years. The first of exceptional weather recurring at long intervals and impossible to predict, the second more frequent but very irregular, the third frequent but still very irregular. The grand difficulty is to recognize the entrance of a special group and grasp its characteristics, whether it is a triad of wet or dry, or cold or warm weather.

He does not claim to be infallible, and is willing to learn from his 'misses'. He casts himself upon a discriminating public, to sink or swim upon the success or failure of his prognostications. What more could be asked from any man?

*Artificial Anæsthesia and Anæsthetics.* By HENRY M. LYMAN, A.M., M.D., Professor of Physiology and Diseases of Nervous System, Rush Medical College, Chicago, Ill. New York: Wm. Wood & Co., 27 Great Jones St.

This is the September number of Wood's Library for 1881, and is really one of the most interesting and important books in the series. Owing to the nature of the subject it is out of the question to attempt a detailed criticism. Suffice it to quote the author's intention "to distil into these pages all the excellences of the writers, who have investigated the subject of Artificial Anæsthesia, and to say, in our humble judgment, he was admirably and wholly succeeded in his, by no means easy, task. The history of the subject, the Phenomena, Physiology, Production, and Forms of Anæsthesia, the administration, accidents and medico-legal relations of Anæsthetics are all ably treated of, and a detailed account of the now numerous Anæsthetic agents furnished in a manner calling for the warmest thanks and felicitations of the profession. Practitioners are to be congratulated upon having so much valuable information brought together into such convenient compass and accessible form, and the author upon having completed so satisfactorily and well his difficult task in his fellow-labourers' behalf. Every one who is called upon to employ these grand alleviators of human suffering and pain, should possess the book and the knowledge which it inculcates.

*Walsh's Physicians' Handy Ledger.* Published by Ralph Walsh, M.D., 332 C Street, North-west, Washington, D.C.

We are in receipt of a copy of this ingeniously conceived and well-executed physicians' ledger, and are certainly disposed to recommend it warmly to all in the profession, who, like ourselves, hate the drudgery of book-keeping. It is issued in either 600 or 1,200 pages, each page sufficing to record a daily attendance on any patient for a full year. Each page contains a blank for patient's name and address; then down the left hand of the page are printed, each on a line below its predecessor, the names of the months; across the page are ruled vertical lines for the days of the month, so that a sign, in its proper square, will suffice to indicate a visit in any day in the year. On the right hand side of the page are ruled three vertical columns, debit, credit, and date of payment, the monthly lines being continued across them. Below are lines for obstetrical, surgical, and miscellaneous annotations, which are also prolonged across the debit and credit columns, thus enabling the whole year's work in connection with any patient to be seen at a glance. An ample index is bound in. The price, post-paid, 600 patients, is \$3.00; 1,200 patients, \$5.00. Walsh's Retrospect, an excellent quarterly summary of Practical American Medicine and Surgery, Walsh's Call Book or Visiting List, and the Handy Ledger will be furnished for \$6.00.—*Verbum sap. sat.*

*Photographic Illustrations of Cutaneous Syphilis.* By G. H. Fox, A.M., M.D., Clin. Lect. on Dis. of Skin, Coll. Phys. and Surgns., New York. Forty-eight Plates from Life, coloured by hand. Nos. 10, 11, and 12. New York: E. B. Treat, 757 Broadway.

The present numbers conclude the series of this highly excellent atlas, in notices of which the vocabulary of encomiums of the medical press has been well-nigh exhausted. The series was undertaken in continuation of the author's "Photographic Illustrations of Skin Diseases," and its appearance has but served to enhance the reputation of both author and artist, of whose first production one of the foremost American dermatologists has said,

"They are, without exception, the most lifelike representations I have ever seen." The present numbers depict with vivid accuracy and great artistic skill 6 cases of syphiloderma ulcerativum, 1 chancre, 1 chancroid, 1 periadenitis, 1 condylomata lata (and for contrast, 1 condylomata acuminata nonsyphilitica), 4 syphilis hereditaria, and 4 dactylitis syphilitica. Where all are so good it seems invidious to make a distinction, but if we were called upon to choose between the present plates we think that the representations of the hereditary affections would be placed *primæ inter pares*. The colouring has been done by J. Gärtner, M.D., a skilful artist and former pupil of Hebra. As marvels of artistic execution they must prove an acquisition to the library shelves or table; and as lifelike representations of affections which everybody meets with, but does not recognize they cannot fail to be helpful to the physician in the hour of harassing perplexity and vexatious doubt. As a good wine needs no bush, so Fox's letterpress needs no commendation.

*Second Annual Report of the State Board of Health, Lunacy, and Charity of Massachusetts, 1880.* Supplement containing the Report and Papers on Public Health.

We have much pleasure in being again reminded by the appearance of this report of the good work being done in the cause of health by the Government of Massachusetts; a striking contrast to the inaction of our own Government, and one which we should all deplore as it affects, and reflects upon, our country.

Year after year the Government of Mass., through this Board, causes an investigation to be made of the natural drainage of various districts, the condition of rivers and streams, how their water supply and drainage influence each other; then the factories, schools, sewerage, and a host of other matters of vital importance come in for attention.

This report contains an able review of the *pros* and *cons* of the two systems, of having storm water, and house sewerage, occupying the same or separate sewers. The conclusion is in favour of the former as a general rule. Memphis has recently adopted the latter plan.

It seems that a few years ago, "a surprising



and interesting event," the appearance of Inter-mittent Fever in Mass., has been noted about the same time that it was much increased with us. Excessive rise and fall of bodies of water is put down as the cause; and drainage the remedy. The paper is interesting as giving a *resumé* of the various theories of the nature and causation of the disease.

School-house sanitation (air, drainage, and water supply), comes in for a large amount of attention, badly needed.

A very good suggestion, and one much needed by us, is added: that every town should have lithograph plans on which year after year the areas of certain diseases can be jotted down.

A novel feature in the volume is a large percentage dial, on which are indicated the various percentages of "sickness," "surroundings," "garbage," "air space," "occupation," "number," "nationality," "sewerage," "drainage," "water," "privies," "cellars." Showing all in a glance in one large picture.

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*Medical Electricity: A Practical Treatise on the Applications of Electricity to Medicine and Surgery.* By ROBERTS BARTHOLOW, A.M., M.D., LL.D. With 96 illustrations. Philadelphia: H. C. Lea's, Son & Co.

Dr. Bartholow, so successful and renowned as a practitioner of the healing art, seems equally successful as a maker of books for the guidance and help of his fellow labourers. Those who had formed high expectations from his "Therapeutics and Materia Medica," his "Practice of Medicine," his "Cartwright Lectures," and his many contributions to periodical medical literature will not be disappointed in perusing his work on Medical Electricity. Indeed his fame as a therapist, both experimental and practical, could scarcely have been acquired in the absence of the knowledge and the qualities this book displays. We have, however, always held that electricity as an element of the materia medica and a therapeutic agent should be treated of in books pertaining to those subjects, and are, therefore, of opinion that Dr. Bartholow would have done, if not wisely, at

least well to have avoided the multiplication of books by appending the present work to the fruit of his labours first above mentioned. This work of some 250 pages is divided into six parts treating respectively of electro-physics, electro-physiology, electro-diagnosis, electro-therapeutics, electricity in surgery, and thermo-electricity. It is sufficiently scientific for the general reader and practitioner, enabling him to understand the principles of the generation of the electric force, the construction and proper handling and care of batteries; and it is eminently practical in clearly setting forth the characteristics and utility of the Galvanic, Faradic, and Franklinic forms, together with the times and modes of their respective applications. It is doubtless true, as Wilks some years ago expressed it, that, the last named form of generation has been too readily superseded by the Galvanic and Faradic currents, and that frictional or static electricity has unaccountably fallen into a desuetude at once premature and undeserved. Queen's Toepler Holtz's electrical machine is stated to be "both highly efficient and certain in operation," and we accordingly hope to see the employment of frictional electricity once more revived. A discovery has been made by our author, or by Morton of New York, we know not which, whereby the Holtz machine can be used as a substitute for faradic electricity, an intelligible account of this will be found at page 217. We are pleased to find that Dr. Bartholow characterizes general electrization and the electric bath as commonly employed as methods of application more profitable in the hands of the charlatan than of the true physician. We are also glad to see the Leclanché element recommended for portable batteries. The therapeutic uses and modes of use of electricity are clearly set forth in entire accordance with accepted scientific views, and demand no further notice. Students and practitioners who have not Poore's little work on electricity will do well to possess themselves of this, which takes rank on a parity beside it, and store in mind the valuable lessons which they alike contain, of the capabilities and scientific use of this potent therapeutic agent so much neglected by the general practitioner.

*A Treatise on Bright's Disease and Diabetes.*

By JAMES TYSON, A.M., M.D., Prof. Pathology and Morbid Anatomy in the University of Pennsylvania. Philadelphia: Lindsay & Blakiston, 1881.

The author of this work is not unknown to literary and didactic fame, and, therefore, we began our perusal of his latest book with pleasurable anticipations and high expectations. We may confess *imprimis* that we have not been disappointed since its pages bear the stamp of the sign manual of the accomplished physician, the intellectual and thoughtful man. The most serious criticism to be made against it is an attempt to compress too much information into too small a space. However, so much has been written on the subject in late years that a summary was earnestly called for; and here the student, as well as the practitioner, who has failed to keep abreast of the tide of recent progress, will find what he needs more conveniently and intelligibly than anywhere else we know of.

Section I. presents an admirable account of the structure of the kidney, following chiefly Heidenhain, Klein, and Beale. The gross structure, the uriniferous tubules, the blood-vessels, the connective tissue, the lymphatics, and the nerves are all shortly but clearly discussed. Some valuable suggestions for studying the history of the kidney are intercalated, and the nature and act of the secretion of urine together with the functions of the kidney are briefly considered. Section II. gives very good directions for testing for albumen. The site of its transudation in albuminuria is located in the Malpighian capsule. In Section III. the subject of tube casts—their nature, and clinical significance—is taken up and treated with great fairness and impartiality. Our author considers them as an exudation from the blood of a fibrinous or albuminous nature coagulating in the tubules, and entangling whatever they contain. Waxy casts are regarded as a fusion and hyaline transformation of desquamated epithelium and other cells. It is admitted that casts may be formed in all parts of the tubules; not so often found in the urine, however, from the convoluted tubules as from the *intercalary* or *intermediary* portion whose structure is

identical with that of the convoluted portion. The author joins issue with Charcot as to the importance and significance of casts, and lays it down as a general proposition that their presence in urine always indicates disease of the kidney, the so-called mucus-cast being of course excepted. Section IV. discusses the classification of Bright's diseases. After citing those of the best authorities in Germany, France, and England, the author adopts the subdivision into acute and chronic; the acute comprising only a single form, the acute parenchymatous nephritis; the chronic including chronic parenchymatous nephritis, lardaceous disease, and interstitial nephritis. In the account of acute parenchymatous nephritis (Section V.) Langhans is closely followed, especially in describing glomerular nephritis, but Klein's contributions to our knowledge of this subject are quite overlooked. The clinical description is very good. In the treatment of convulsions the author's voice is raised, we think, wisely, against the growing practice of using morphia as introduced by Loomis. Sections VI. and VII. are also admirable summaries of existent knowledge, though the nature of the lardaceous substance is not discussed. The author, although not mentioning the matter expressly, would not, we judge from the general tenor of his remarks, agree with Straus in holding that some cases of lardaceous kidney may run their course without albuminuria from first to last. In Section VIII. on interstitial nephritis in referring to the causation, Dr. Clifford is cited as the author of the theory of mental anxiety as an etiological factor; the name should, of course, be Clifford Albutt. Johnson's stopcock-action theory to account for the vascular and cardiac hypertrophy is ably defended by our author, but he does not omit to give DaCosta and Longstreth's late renal ganglia change theory a passing notice. On the top line of page 180 the word "capillaries" has crept in, we think, by mistake, for "arterioles." The therapeutics throughout are very good, but no mention is made, and we, therefore, assume that our author has no experience, of the use of nitro-glycerine (glonoin) in relieving the high vascular tension, or of the nitrite of amyl for the same purpose



and for the relief of uræmic asthma. According to Saundby the headache and vertigo may frequently be relieved by Theine or Caffeine. No reference is likewise made to the occasional occurrence of albuminuria in health as found by Leube in soldiers, or to that form described as of adolescence by Clement Dukes, of Rugby, and also by Moxon. Section IX. is devoted to retinitis in Bright's disease, and is contributed by Wm. F. Norris, A.M., M.D., Clinical Professor of ophthalmology in the University. Sections X. and XI. discuss the subjects of suppurative interstitial nephritis and cystotic induration respectively, which, although not pertaining strictly to the subject of Bright's disease, are added for the purpose of greater completeness. Diabetes mellitus and insipidus occupy the last 80 pages of the book presenting a very good *resumé* of the subject. Certainly, taken as a whole, the work does infinite credit to the erudition and industry of its author; and, from the student's and busy general practitioner's standpoint, constitutes a valuable addition to medical literature in the English language.

### Meetings of Medical Societies.

#### HURON MEDICAL ASSOCIATION.

The regular quarterly meeting of the Huron Medical Association, was held in Wingham, on the 4th of October, Dr. Sloan, President in the chair. The following members were present: Drs. Sloan, Holmes, Worthington, Tambllyn, Bethune, Graham, McDonald, Gillies, Young, Duncan, Mackid, Hurlburt, and Stewart.

Dr. Mackid showed a woman, aged 65, who has an abdominal tumor, occupying a great portion of the right abdominal cavity. She first noticed it four months previously. Its true nature was not clear.

Drs. Stewart and Hurlburt showed the following cases:—

1. A case of locomotor ataxia. The patient is a man, aged 43. He was first seen on the first of September, of the present year, when he complained of shooting pains in his legs, thighs, arms, and belly, and of an inability to walk in the dark. He had gonorrhœa twenty years ago, but he never had syphilis. His previous and family history are good. The pains first troubled him twelve years ago, while he was working in the lumber woods of Wisconsin. His occupation was that of a driver, and he had to sit for hours on the cold logs, and it is to this that he attributes his trouble. The pains have been gradually becoming severer. He has been unable to work for nine months. The first difficulty in walking was noticed five years ago.

*Present state.* There is no loss of motion in any of the extremities. The sensation of the lower limbs, and that part of the left arm, supplied by the median is markedly delayed. He requires from 6 to 8 seconds to appreciate a painful sensation in these parts. Simple brushing the hair of the legs causes more pain than severe pinching. He is able to tell a hot from a cold application. When his eyes are shut he is unable to touch his nose with either index finger, neither can he point correctly to the position of his feet. There is complete absence of the knee reflex. There is no ankle clonus. He says that he is able to retain his urine for 48 hours without causing him any inconvenience. When he attempts to empty his bladder he is compelled to strain and it often takes him half an hour to get all the urine away. Bowels move about every third day. The pupils contract to light slowly. The reaction to accommodation is normal. There is no myosis, squinting, or loss of color vision. There is distinct atrophy of both discs. Vision is fair. He at times complains of severe pains in his stomach. He says that he has a feeling as if a hundred pound weight was compressing his back. He is unable to stand or walk with his eyes closed. A full clinical account of this case, with a detailed description of the effects of stretching the right sciatic, which operation was performed since the meeting of the Association, will be published shortly.

2. A case of probable tumor of the left cerebral motor region. The patient, a girl aged 14½ years, was first seen in January, 1880, when she complained of loss of vision in the left eye and headache. Family and personal history good. She was quite well until three years ago, when she was seized with headache, confined to the left parietal region and vomiting. After these symptoms had been present for three weeks, she accidentally discovered that there was complete loss of vision in her left eye. The headache and vomiting disappeared shortly afterwards, but have recurred frequently since. The following was her condition in January, 1880. She is medium-sized, spare and listless looking, her cheeks flush frequently. The pulse is 90 and the temperature normal. There is nothing abnormal to be detected about the heart, lungs, liver, or spleen. The appetite is poor and the bowels costive. Abdomen retracted. Marked *taches cérébrales*.

*Left Eye.*—Slight upward and internal squint. The arteries of the fundus are small and no white lines can be discovered accompanying them. The disc is greyish white, small and cupped. *Right Eye.*—The disc is larger and of the normal colour, but there is some cupping. Vessels small. Fundus otherwise normal. The media are normal in both eyes. The sight of

the right eye is good. Left eye completely blind. The left pupil is dilated, the right is normal. From this time (January, 1880,) for a period of about four months, she took 40 grains of iodide of potassium daily. Shortly after commencing its use the headache disappeared, and has not returned. About five months ago, right hemiplegia set in, and at the present time the right arm is completely useless. She is able to walk but drags her right leg considerably in doing so. Both hemiplegic limbs are atrophied, but not rigid. The right knee reflex is greatly exaggerated. She is a great sleeper.

Drs. Stewart and Hurlburt also showed the fragments of a phosphatic stone weighing two ounces which they removed from the bladder of a girl, aged 16. The stone had formed around a hairpin which had been introduced eighteen months previously.

Dr. Graham, of Brussels, showed a man 50 years of age, who had apparently recovered from both a psoas and lumbar abscess depending on disease of the dorsal vertebrae. For several months this patient has been troubled with catarrh of the bladder and bacterurium. The urinary deposit is composed principally of large quantities of pus cells and bacteria termo. For this condition he has been taking and with great benefit eucalyptus internally, and injections into the bladder of the disulphate of quinine.

#### TORONTO MEDICAL SOCIETY.

October 6th.—The Society met at eight o'clock. After the reading of the Minutes, Dr. Jonathan Robinson was proposed as a member.

Dr. Oldright presented the fœtus and placenta taken from a patient supposed to have miscarried about the fifth month. The fœtus was of very small size, and the placenta had undergone fatty degeneration; the smallness of the fœtus was thought to be due to the fatty condition of the placenta. The amnion was adherent to the body of the fœtus. He also showed a placenta from a case of premature birth at the seventh month. There had been considerable hæmorrhage prior to the birth of the child, and the placenta presented on its uterine surface two large clots which appeared to have been formed at different times. The child was still-born, and presented the condition of *rigor mortis*. The cause of the placental separation could not be ascertained.

Dr. Burns related a case of *Pruritus Hiemalis*, as described by Duhring. It is a neurosis, attacking principally the arms and thighs, and is a disease of cold weather, whence its name. Treatment by glycerine, vaseline, and the Turkish bath is recommended.

October 27th.—The Society met at 8.15 p.m. President in the chair. After the reading of the Minutes, Dr. J. Robinson was elected a member.

Dr. J. S. King showed a pessary which he had removed after a sojourn in the vagina of four years. It was firmly fixed on the right side of the uterus by a fibrous band about three-fourths of an inch in width. The pessary was divided and then removed.

Dr. Workman mentioned a case of acute mania, occurring in a patient in consequence of an encrusted pessary in the vagina.

Dr. Cameron exhibited a patient suffering from "paralysis agitans," affecting the right upper and lower extremities in a female patient aged 67. The trembling was of three years' duration, and increased upon excitement or voluntary motion. In reply to a question, Dr. Cameron thought that there was no definite or constant pathological change in this disease, but that it was a functional disorder.

Dr. McPhedran then showed a case of albuminuria and dropsy in a boy aged 18. The disease was of eight weeks' duration. The patient when examined at the hospital presented the following conditions:—anæmia and general anasarca, abdomen enlarged partly from ascites and partly from tympanites; apex beat of heart under left nipple; enlarged spleen, and slight enlargement of some of the lymphatic glands; urine highly albuminous, contained granular and epithelial casts, and the voice was lost beyond a whisper. Dr. Graham, after describing Gowers's Hæmacytometer, examined the blood of the patient, and found no increase in the number of the white blood corpuscles, but a diminution in the red. Dr. Reeve examined the eyes ophthalmoscopically and found recent slight optic neuritis and a small hæmorrhage.

The second regular meeting of the Quinte and Cataraqui Medical Association was held in the Masonic Hall, at Napanee, on the 5th of October, for the purpose of completing their organization. Dr. W. G. Metcalf, Medical Superintendent, Asylum for Insane, Kingston, and Vice-President for Frontenac occupied the chair. The gentlemen present were: Drs. Metcalf, Henderson, Oliver, M. Lavell and C. H. Lavell, of Kingston; Drs. Burdett and Eakins of Belleville; Drs. Cowan, Ward and Leonard, Napanee; Dr. M. I. Beeman, of Centreville; Dr. Evans, of Odessa; Dr. Platt, Wright and Beaman, jun., of Picton; and Dr. Bowerman, of Bloomfield. The only business of importance transacted at this meeting was the reading and adoption of a constitution. The Association adjourned to meet in Belleville, in February next.









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